

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

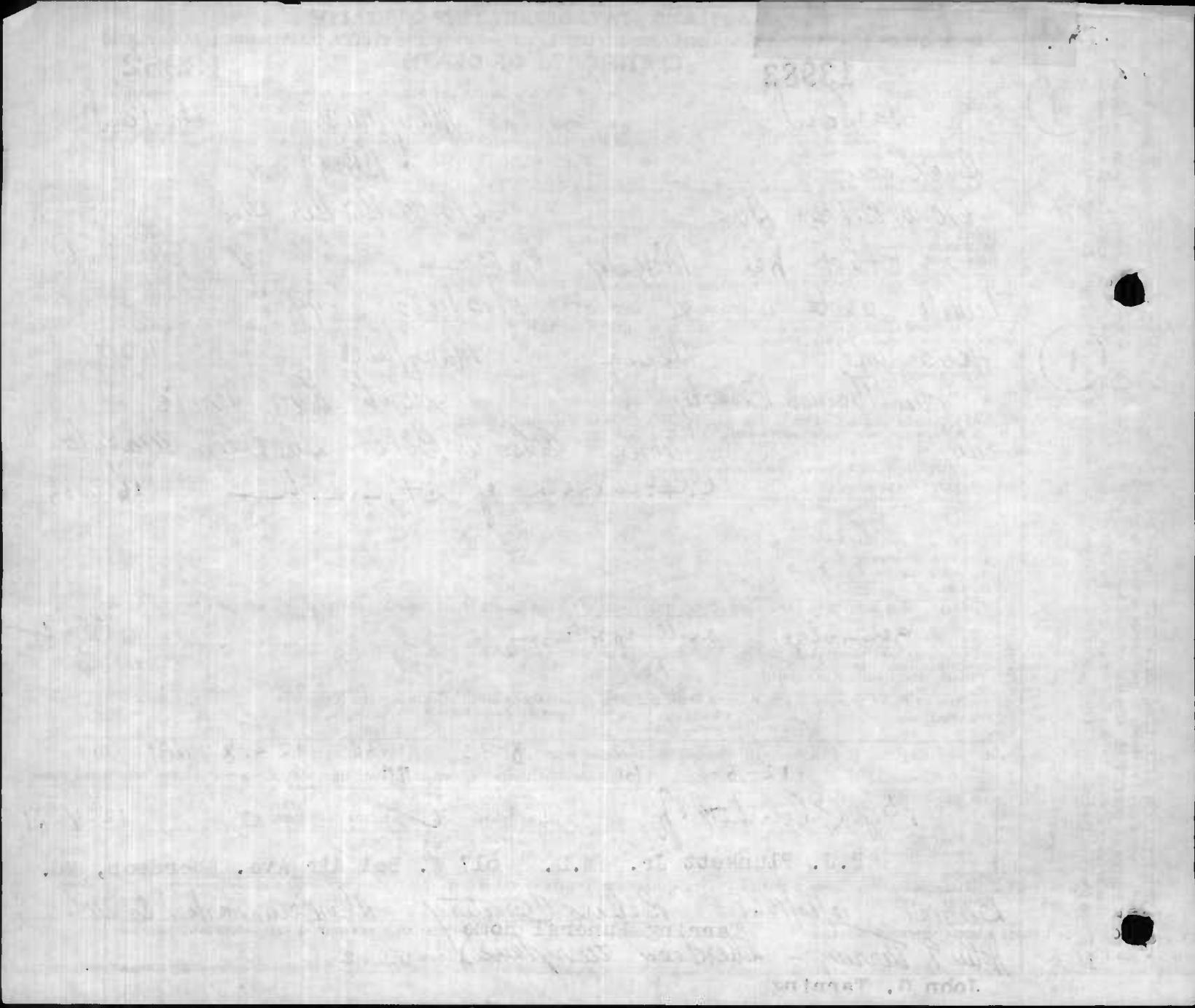
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13983

13952

1. PLACE OF DEATH a. COUNTY Harford		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Aberdeen		c. LENGTH OF STAY IN 1b 28		2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission) a. STATE Maryland		b. COUNTY Harford		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Aberdeen			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 610 W. Bel Air Ave.		e. STREET ADDRESS 610 W. Bel Air Ave.		f. DATE OF DEATH 12 8 1961		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Ethel Lee Ridgely		First Ethel	Middle Lee	Last Ridgely	Baker	Month Dec	Day 8	Year 1961					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11/13/1882		9. AGE (In years last birthday) 79 yrs.		10. IF UNDER 1 YEAR Months 0		11. IF UNDER 24 HRS. Hours 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (County & State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME John Thomas Ridgely		14. MOTHER'S MAIDEN NAME Sarah Ann Jervis											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT None Chas W. Baker - Aberdeen Maryland		Address							
18. CAUSE OF DEATH (Enter only one cause per line for (e), (b), and (c).)		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) 151X		DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.		Carcinoma of stomach		INTERVAL BETWEEN ONSET AND DEATH 16 mos					
		(b)		(c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)		generalized arteriosclerosis										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20e. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Hour e.m. p.m. 19		Month, Day, Year		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) 8-23		(County) 1961		(State)	
21. I certify that (I) (this hospital) attended the deceased from..... saw the deceased alive on.....		to.....											
22a. SIGNATURE B.J. Plunkett Jr.		M.D.		ATTENDING PHYS. ✓		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 12-9-61			
22c. PHYSICIAN'S NAME (Type) B.J. Plunkett Jr.		M.D.		22d. ADDRESS 617 W. Bel Air Ave. Aberdeen, Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/10/1961		23c. NAME OF CEMETERY OR CREMATORIAL Bakers Cemetery		23d. LOCATION (City, town, or county) Aberdeen, Harford Co. Md.							
24. FUNERAL DIRECTOR'S SIGNATURE John G. Tarring - Aberdeen, Maryland		Tarring		ADDRESS Funeral Home		25a. REC'D BY REGISTRAR DATE DEC 12 '61		25b. REGISTRAR'S SIGNATURE J. Tarring					
A15 (4) 15M 9/60													



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13984

13984

1. PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)	
Harford				a. STATE	Maryland
b. CITY OR TOWN (if outside corporal's limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		b. COUNTY	Harford
Aberdeen Proving Ground		1 month		c. CITY OR TOWN (If outside corporal's limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				d. STREET ADDRESS	28 Aberdeen
USA Army Hospital, Aberdeen Proving Ground				109 H Rodman Road	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print)		First	Middle	4. DATE OF DEATH	Month Day Year
CLIFTON		WILLIAM	BAYNARD JR	DECEMBER	11 1961
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday) IF UNDER 1 YEAR 5 yrs. Months Days Hours Min.
Male		Negroid	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	20 July 1956	IF UNDER 24 HRS.
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)	
None		N/A		St Alban's, New York	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
CLIFTON W. BAYNARD		HELEN E. GOWENS			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT	
N/A		N/A		Clifton W. Baynard (Father) Same as Item #2	
Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Wilms Tumor, left kidney</u>		8 months			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)					
DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
19				20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from... 16 November 1961 to 11 December 1961, that (I) <input checked="" type="checkbox"/> last saw the deceased alive on... 11 December 1961..., and that death occurred at 4:15 PM from the causes and on the date stated above.					
22e. SIGNATURE <i>Malcolm McLean</i>		22b. DATE SIGNED 11 Dec 61			
22c. PHYSICIAN'S NAME (Type) MALCOLM MCLEAN, Captain, MC		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
22d. ADDRESS US Army Hospital, Aberdeen Proving Ground, Maryland					
23a. BURIAL, CREMATION REMOVAL (Specify) Burial 12-16-61		23b. DATE THEREOF 12-16-61		23c. NAME OF CEMETERY OR CREMATORIAL Whitewell Cemetery	
23d. LOCATION (City, town or county) (State) Dover Del.					
24 FUNERAL DIRECTOR'S SIGNATURE James Deshields		ADDRESS Eaton, Md.		25e. REC'D BY REGISTRAR DEC 15 '61	
25b. REGISTRAR'S SIGNATURE John S. Krause					

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

121

1

2

1
FOR STATE
HEALTH DEPT.

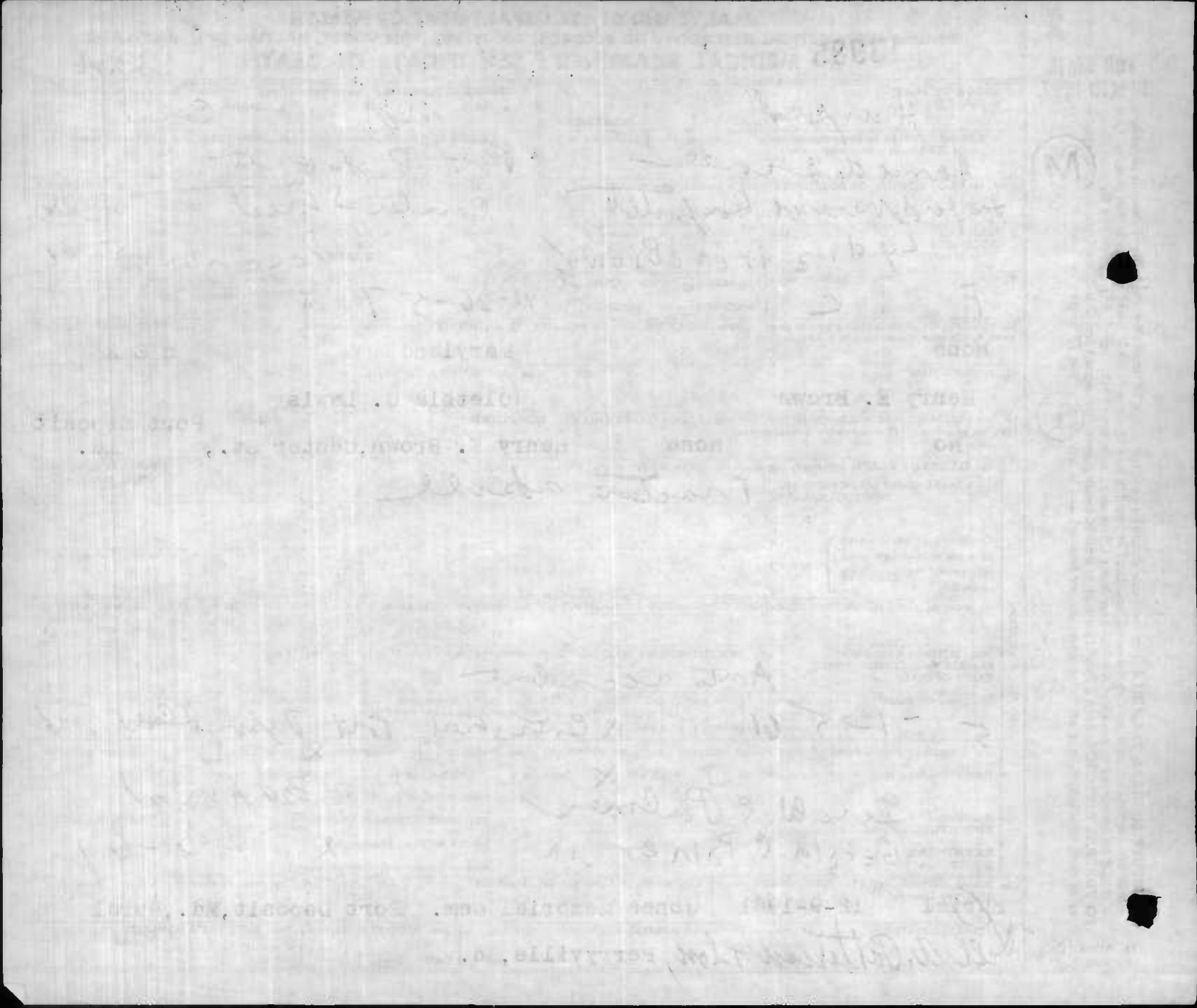
DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13985 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13954

1. PLACE OF DEATH a. COUNTY		Maryland		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)	
<i>Hanford</i>				a. STATE <i>No</i>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		b. COUNTY <i>Cecil</i>	
<i>Same as above</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				Port Deposit	
<i>Hanford Nursing Hospital</i>				d. STREET ADDRESS <i>Center Street</i>	
3. NAME OF DECEASED (Type or print)		First <i>Lydia</i>	Middle <i>Irene</i>	Last <i>Brown</i>	4. DATE OF DEATH <i>December 19 61</i>
5. SEX <i>F</i>		6. COLOR OR RACE <i>C</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>11-26-57</i>	9. AGE (In years last birthday) <i>4 yrs.</i>
WIDOWED <input type="checkbox"/>		DIVORCED <input type="checkbox"/>		IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i>	IF UNDER 24 HRS. Hours <i>0</i> Min. <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Henry E. Brown		14. MOTHER'S MAIDEN NAME Olethia O. Lewis		12. CITIZEN OF WHAT COUNTRY? U S A	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Port Deposit Henry E. Brown, Center St., Md.	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Fracture skull		INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO (b)			
		DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 1b.) Auto accident			
20c. TIME OF INJURY Month, Day, Year Hour 12 p.m. 5 1961		20d. INJURY OCCURRED While at work Not While at work	20e. PLACE OF INJURY (Home, farm, factory, street, office building, etc.) Center Street Port Deposit Cecil Md	(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. Gerald C Palmer Baltimore			
ACTUAL SIGNATURE Gerald C Palmer		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county) 12-6-61			
EXAMINER'S NAME (Type) Gerald C Palmer MD		DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-9-1961	22c. NAME OF CEMETERY OR CREMATORIAL Jones Memorial Cem.	22d. LOCATION (City, town, or country) Port Deposit, Md., Rural	(State)
23. FUNERAL DIRECTOR Kel A. Patterson & Son, Perryville, Md.		ADDRESS	24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE Arthur S. Tracy	DATE DEC 11 '61



1
FOR STATE
HEALTH DEPT.

1-10-62 File 305 MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13985

13955

1. PLACE OF DEATH

a. COUNTY

Harford

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Havre de Grace

c. LENGTH OF STAY IN lb

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Harford Memorial Hospital

3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

4. DATE
OF
DEATH

Month December 30 19 61

5. SEX

6. COLOR OR RACE

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

5/1/07

9. AGE (In years
last birthday)

54 yrs.

IF UNDER 1 YEAR

IF UNDER 24 HRS.

Months Days

Hours Min.

Female

White

WIDOWED

DIVORCED

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

BAR MAID

10b. KIND OF BUSINESS OR INDUSTRY

TAVERN

11. BIRTHPLACE (State or foreign country)

MD

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

?

14. MOTHER'S MAIDEN NAME

?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service)

—

16. SOCIAL SECURITY NO.

219-34-4846

17. INFORMANT

Address MAIN ST
ALLISTER ARCHER-BURTON EDGEWOOD MD

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Salicylate Intoxication

970.5

DUE TO

Conditions, if any, which
gave rise to Immediate cause
(a), stating the underlying
cause last.
(b)

DUE TO

(c)

INTERVAL BETWEEN
ONSET AND DEATH

2
MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

Salicylate ingestion

20c. TIME OF INJURY Month, Day, Year
Hour a.m.

PMX 12/30 19 61

20d. INJURY OCCURRED
While Not While
at work at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

Home

20f. (City or town)

(County)

(State)

Edgewood Harford Md.

21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and in my opinion
death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined manner

ACTUAL
SIGNATURE

Charles S. Petty

CHIEF MEDICAL EXAMINER

M.D. ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

DATE SIGNED

12/31/61

EXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

Address (Street, city, town, or county)

22a. BURIAL, CREMATION,
REMOVAL (Specify)

BURIAL

22b. DATE THEREOF

11/3/62

22c. NAME OF CEMETERY OR CREMATORI

WOODLAWN

22d. LOCATION (City, town, or country)

WOODLAWN MD

(State)

23. FUNERAL DIRECTOR

ADDRESS

Paul E. Chernoweth 345 Bluestone Ave

24a. REC'D BY REGISTRAR

JAN 3 '62

24b. REGISTRAR'S SIGNATURE

Arthur S. Name

M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13987

CERTIFICATE OF DEATH

Reg. No. 13956

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Harve de Grace 6 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Benson	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Harford Memorial		d. STREET ADDRESS Harford Rd.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Hazel E. Carl		First Middle Last	4. DATE OF DEATH December 6, 1961
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> b. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> January 11, 1886	9. AGE (In years, last birthday) 75 yrs. 10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME William H. McElroy		14. MOTHER'S MAIDEN NAME Annie McElroy	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -----	17. INFORMANT G. Herman Carl
			Address Benson, Maryland
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) Chronic cardio-vascular disease			
INTERVAL BETWEEN ONSET AND DEATH 1 week			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) Diabetes Mellitus			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from November 29, 1961, to December 6, 1961, that I last saw the deceased alive on December 6, 1961, and that death occurred at 8:30 P.M., from the causes and on the date stated above. ACTUAL SIGNATURE Willard P. Hudson, M.D. PHYSICIAN'S NAME (Type) Willard P. Hudson, M.D. ADDRESS (Street, city or town, state) Forest Hill, Maryland DATE SIGNED December 7, 1961			
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 12/11/1961	22c. NAME OF CEMETERY OR CREMATORIAL Greenmount
22d. LOCATION (City, town, or county) Baltimore		(State) Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Charles E. Keay, Garrettsville, Md.		ADDRESS	24a. REC'D BY REGISTRAR DEC 11 '61
			24b. REGISTRAR'S SIGNATURE Charles J. Thorne

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
13988 1. PLACE OF DEATH a. COUNTY Harford b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Aberdeen Proving Ground c. LENGTH OF STAY IN 1b 2 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) US Army Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland b. COUNTY Harford c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 28 Aberdeen d. STREET ADDRESS 602 Plater Street							
3. NAME OF DECEASED (Type or print) (REDACTED) Vincent - Joseph - COSTA				4. DATE OF DEATH Month Day Year December 10 19 61				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 8 December 1961		9. AGE (In years last birthday) yrs. 2		10. IF UNDER 1 YEAR Months Days Hours Min. 0 0 0 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Not applicable				10b. KIND OF BUSINESS OR INDUSTRY US Army Hospital, Aberdeen Proving Ground, Md				11. BIRTHPLACE (County & State or foreign country) USA			
12. CITIZEN OF WHAT COUNTRY? USA											
13. FATHER'S NAME Carmen Frank Costa				14. MOTHER'S MAIDEN NAME Beulah Ferl Caudill							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give rank and date of service) No				16. SOCIAL SECURITY NO. None				17. INFORMANT Carmen F Costa (Father) Same as Item #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gross prematurity DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> Congenital			
20c. TIME OF INJURY Hour a.m. p.m.		Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) US Army Hospital, Aberdeen Proving Ground, Maryland		20f. (City or town) Aberdeen Proving Ground, Maryland		(County) Maryland	
21. I certify that (I) (this hospital) attended the deceased from 8 Dec 61 , 19, to 10 Dec 61 , 19, that (I) (we) last saw the deceased alive on 10 Dec 61 , 19, and that death occurred at Aberdeen Proving Ground, Maryland , from the causes and on the date stated above.											
22a. SIGNATURE Thomas J Fraher MD				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED 10 Dec 61			
22c. PHYSICIAN'S NAME (Type) THOMAS J FRAHER, MD				22d. ADDRESS US Army Hospital, Aberdeen Proving Ground, Maryland							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/13/1961		23c. NAME OF CEMETERY OR CREMATORIAL Post Cemetery		23d. LOCATION (City, town or county) Aberdeen Proving Ground, Maryland		(State) Maryland			
24. FUNERAL DIRECTOR'S SIGNATURE John G. Tarring - Aberdeen, Maryland				ADDRESS 2050292 XVO				25a. REC'D BY REGISTRAR Dec 13 '61		25b. REGISTRAR'S SIGNATURE Anthony S. Tamm	

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

MARYLAND
13958

13989

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after Page 4 may be retained by the hospital or attending physician.

CORPORATION FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)	
<i>Hanover Maryland</i>		a. STATE <i>Maryland</i>	b. COUNTY <i>Hanover</i>
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
c. LENGTH OF STAY IN lb			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First <i>Carlton</i>	Middle <i>Fletcher</i>
		Last <i></i>	4. DATE OF DEATH <i>12/14/61</i>
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <i>Oct. 10 1916</i>
		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. AGE (In years last birthday) <i>45</i> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <i>Painter</i>	
<i>Retired</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Hanover Grace Md. U.S.A.</i>	
13. FATHER'S NAME <i>O. Frank Fletcher</i>		14. MOTHER'S MAIDEN NAME <i>Bertha Neause</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>Unknown</i>		16. SOCIAL SECURITY NO. <i>Unknown</i> 17. INFORMANT <i>Orth Fletcher</i> Address <i>610 Delago Hanover</i>	
(If yes, give rank and dates of service)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		19. INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pulmonary Oedema</i> <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, } (b) <i>Coronary Thrombosis</i> DUE TO (c) <i>Hypocarditis</i>		5 minutes	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		5 minutes	
		5 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i>Hanover</i> (County) <i>Maryland</i> (State) <i>Maryland</i>	
21. I certify that (I) (this hospital) attended the deceased from <i>June 1940</i> to <i>Dec 15, 1961</i> , that (I) (we) last saw the deceased alive on <i>Dec 14, 1961</i> , and their death occurred at <i>2A M</i> , from the causes and on the date stated above.		22b. DATE SIGNED <i>Dec 15, 1961</i>	
22a. SIGNATURE <i>Frank Wolbert MD</i>		ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>
22c. PHYSICIAN'S NAME (Type) <i>FRANK WOLBERT MD</i>		22d. ADDRESS <i>HAURE DE GRACE MARYLAND</i>	
23a. BURIAL CREMATION, REMOVAL (Specify) <i>12/17/61</i>		23b. DATE THEREOF <i>12/17/61</i> 23c. NAME OF CEMETERY OR CREMATORIAL <i>Chesapeake</i>	
		23d. LOCATION (City, town or county) <i>Anne Arundel Md.</i> (State) <i>Maryland</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Pauline J. P. Hanover</i>		ADDRESS <i>Hanover Grace Md.</i>	25a. REC'D BY REGISTRAR <i>Arthur S. Thomas</i> DATE <i>DEC 20 '61</i> 25b. REGISTRAR'S SIGNATURE <i>Arthur S. Thomas</i>

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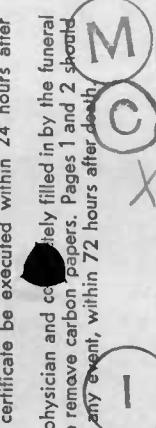
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
 15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18												
CERTIFICATE OF DEATH												
Reg. Dist. No. 13959												
1. PLACE OF DEATH a. COUNTY Harford				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland								
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Joppa				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Joppa								
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pulaski Hyway & Joppa Road				d. STREET ADDRESS Pulaski Hyway & Joppa Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		First Robert	Middle	Lost	4. DATE OF DEATH Forrester	Month Dec.	Day 21	Year 1961				
5. SEX M		6. COLOR OR RACE C	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 8 1876		9. AGE (In years last birthday) 85 yrs.	10. IF UNDER 1 YEAR Months 8	11. IF UNDER 24 HRS. Days 5	12. IF UNDER 24 HRS. Hours 14	13. IF UNDER 24 HRS. Min. 41		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) Maryland				
12. CITIZEN OF WHAT COUNTRY? U.S.A.												
13. FATHER'S NAME Thomas Forrester				14. MOTHER'S MAIDEN NAME Ann Tasker								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.				17. INFORMANT Mrs Priscilla Forrester Address Pulaski Hywy. Joppa Road				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]												
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO Cerebrovascular Accident INTERVAL BETWEEN ONSET AND DEATH 14 hr.												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic CVD												
DUE TO (c)												
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)	
21. I certify that I attended the deceased from Oct. , 1960, to Oct. 21, 1961 , that I last saw the deceased alive on Dec. 20, 1961 , and that death occurred at 8 A.M. from the causes and on the date stated above.								ADDRESS (Street, city or town, state)		DATE SIGNED		
ACTUAL SIGNATURE William A. Tyson				M.D.				Kingsville, Md.		12-21-61		
PHYSICIAN'S NAME (Type)												
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-26-61		22c. NAME OF CEMETERY OR CREMATORIAL Community Bapt.Chr.Cem				22d. LOCATION (City, town, or county) (State) Harford Co., Md.				
23. FUNERAL DIRECTOR'S SIGNATURE McLeaster Stanley		ADDRESS 578 W. Bidder St.		REG'D BY REGISTRAR St. 2701		DATE		24b. REGISTRAR'S SIGNATURE John L. Moore				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and countersigned by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



VR A15 (4)
15M 9/60

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13991

13960

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Harford		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland		b. COUNTY Harford		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Street	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural - Street		c. LENGTH OF STAY IN 1b 3 wks.		d. STREET ADDRESS Rural - Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First Elizabeth	Middle Christine	Last Freeman	4. DATE OF DEATH Month December Day 20, 1961	Year			
5. SEX F		6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 17, 1961		9. AGE (In years last birthday) yrs. 4	10. IF UNDER 1 YEAR Months 3	11. IF UNDER 24 HRS. Hours 3	12. CITIZEN OF WHAT COUNTRY? USA
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ----		10b. KIND OF BUSINESS OR INDUSTRY ----		11. BIRTHPLACE (County & State, or foreign country) Havre de Grace, Md.		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Estil Freeman		14. MOTHER'S MAIDEN NAME Louise Combs		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes give war and dates of service) ---		16. SOCIAL SECURITY NO. ---		17. INFORMANT Estil Freeman, Street, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) 776X		DUE TO Prematurity		INTERVAL BETWEEN ONSET AND DEATH ____					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. ____		(b) DUE TO 776X		(c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(e)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from... Dec 20, 1961 to Dec 20, 1961 that (I) (we) last saw the deceased alive on... Dec 20, 1961 , and that death occurred at 12:30 P.M. from the causes and on the date stated above.									
22e. SIGNATURE Joseph A. Hunt		M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 12/21/61			
22c. PHYSICIAN'S NAME (Type) Joseph A. Hunt, MD		22d. ADDRESS Delta, Pa.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec. 22, 1961		23c. NAME OF CEMETERY OR CREMATORIAL Fellowship		23d. LOCATION (City, town or county) Pylesville, Md.		(State)	
24. FUNERAL DIRECTOR'S SIGNATURE John H. Hartman		ADDRESS Delta, Penna.		25e. REC'D BY REGISTRAR DATE DEC 26 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Thorne			

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13992

CERTIFICATE OF DEATH

13961

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Harford		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Haure de Grace		c. LENGTH OF STAY IN 1b 4 days	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Harford Memorial Hospital		e. STREET ADDRESS Rt 1 Always Inn	
3. NAME OF DECEASED (Type or print) David Lewis Grace		f. DATE OF DEATH December 24 1961	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED		8. DATE OF BIRTH 3/16/1872	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed		10b. KIND OF BUSINESS OR INDUSTRY Unknown	
11. BIRTHPLACE (County & State, or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAMES David Grace		14. MOTHER'S MAIDEN NAME Isabell Minton	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> If yes, give war or dates of service) Unknown		16. SOCIAL SECURITY NO. James P. Grace, Street, Md.	
17. INFORMANT James P. Grace, Street, Md.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY; IMMEDIATE CAUSE (a) Cerebral hemorrhage - left hemiplegia 4 days	
DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.		(b) DUE TO Hypertensive and arteriosclerotic cardiovascular disease	
DUE TO 3-4 years		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e) Terminal pneumonia.		19. WAS AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Dec. 20th, 1961 to Dec. 24th, 1961	
20c. TIME OF INJURY Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Haure de Grace, Md.		20f. (City or town) (County) (State)	
21. I certify that (I) (his hospital) attended the deceased from Dec. 20th, 1961 to Dec. 24th, 1961 , that (I) (we) last saw the deceased alive on Dec. 24th, 1961 , and that death occurred at 8P.M. from the causes and on the date stated above.		22b. DATE SIGNED 12/24/61	
22a. SIGNATURE Edward C. Zoo		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS Haure de Grace, Md.	
22c. PHYSICIAN'S NAME (Type) Edward C. Zoo, M.D.		23d. LOCATION (City, town or county) (State) Anne Arundel, Md.	
23a. BURIAL CREMATION, REMOVAL (Specify) 12/27/61		23b. DATE THEREOF 12/27/61	
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Oak Grove		25a. REC'D BY REGISTRAR DATE DEC 29 '61	
24. FUNERAL DIRECTOR'S SIGNATURE Frederick J. Zoo, Harford, Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

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HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13993		13962	
1. PLACE OF DEATH a. COUNTY <i>Harford</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Harford</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Havre de Grace</i>		c. LENGTH OF STAY IN 1b <i>1 day</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Harford Memorial</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Belair</i>	
3. NAME OF DECEASED (Type or print) <i>Nictie M. Greer</i>		4. DATE OF DEATH <i>12 11 1961</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Oct 12 1888</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Nose</i>		10b. KIND OF BUSINESS OR INDUSTRY	
		11. BIRTHPLACE (State or foreign country) <i>Grayson Co Va</i>	
13. FATHER'S NAME <i>Linder Cole</i>		14. MOTHER'S MARRIED NAME <i>Dorothy Weaver</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <i>Geo Greer Bel Air Md</i>	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Massive Cerebral Hemorrhage</i> DUE TO <i>443X</i> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <i>Hypertensive Cardiovascular Disease 3 years</i> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Diabetes Mellitus</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Dec 11th 1961</i>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i>Dec 11th 1961</i> (County) <i>Dec 11th 1961</i> (State) <i>Dec 11th 1961</i>	
21. I certify that (I) (this hospital) attended the deceased from <i>Dec 11th 1961</i> , to <i>Dec 11th 1961</i> , that (I) (we) last saw the deceased alive on <i>Dec 11th 1961</i> , and that death occurred at <i>245 M.</i> , from the causes and on the date stated above.			
22a. SIGNATURE <i>Edward C. Hoorn</i>		22b. DATE SIGNED <i>12/11/61</i>	
22c. PHYSICIAN'S NAME (Type) <i>Edward C. Hoorn, M.D.</i>		22d. ADDRESS <i>Havre de Grace, Md.</i>	
23a. BURIAL OR CREMATION REMOVAL (Specify) <i>Dec 12, 1961</i>		23c. NAME OF CEMETERY OR CREMATORIUM <i>Sparta M. C.</i>	
23d. LOCATION (City, town, or county) <i>M. C.</i>		(State)	
24. FUNERAL DIRECTOR'S SIGNATURE <i>A. & Bailey Darlington</i>		25a. REC'D BY REGISTRAR <i>DEC 15 '61</i>	
ADDRESS		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Knapp</i>	

1333



HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13994

13963

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <i>Hartford</i>		2. USUAL RESIDENCE (Where deceased lived, If institutional, residence at time of admission) a. STATE <i>Md</i>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Havre de Grace</i>		c. LENGTH OF STAY IN 1b <i>15 days</i>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Hartford Memorial Hospital</i>		e. STREET ADDRESS <i>Forest Hill</i>	
3. NAME OF DECEASED (Type or print) <i>Chester</i>		4. DATE OF DEATH Last Month Dey Year <i>Grier 12 - 20 1961</i>	
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <i>MAY 27, 1882</i>	
WIDOWED <input type="checkbox"/>		DIVORCED <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>NURSERY man</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Ret. Nurseyman</i>	
11. BIRTHPLACE (County & State, or foreign country) <i>PIKESVILLE, Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>John T. Grier</i>		14. MOTHER'S MAIDEN NAME <i>Mary A. Grier</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes give rank or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>—</i>	
17. INFORMANT <i>MRS SYVILLA H. GRIER FOREST HILL MD</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i>		<i>CORONARY THROMBOSIS</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b)		<i>Chr CardioVascular Disease</i> ?	
DUE TO } (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>May 27, 1961</i> , to <i>Dec 20, 1961</i> , that (I) (we) last saw the deceased alive on <i>Dec 19, 1961</i> , and that death occurred at <i>2 P.M.</i> from the causes and on the date stated above.		22b. DATE SIGNED <i>12/20/61</i>	
22a. SIGNATURE <i>Willard P. Hudson M.D.</i>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <i>—</i>		22d. ADDRESS <i>FOREST HILL, Md</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE THEREOF <i>12/23/61</i>	
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <i>DEER CREEK</i>		23d. LOCATION (City, town or county) (State) <i>CHESTNUT HILL MD.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Charles E. Kurtz Jarrettsville Md.</i>		25e. REC'D BY REGISTRAR DATE <i>DEC 27 '61</i>	
		25b. REGISTRAR'S SIGNATURE <i>Charles E. Kurtz</i>	

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13995

13964

CERTIFICATE OF DEATH

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

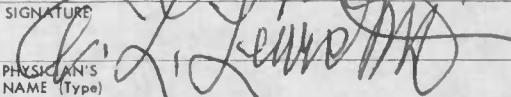
FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH b. COUNTY	HARFORD MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN b RURAL HAVRE DE GRACE 16 YRS.	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)	R.D. 1 Box 1	

2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission)	
a. STATE No.	b. COUNTY HARFORD
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	RURAL HAVRE DE GRACE X
d. STREET ADDRESS R.D. 1 - Box 1	1
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	1
4. DATE OF DEATH DEC. 17 1961	Month Day Year

3. NAME OF DECEASED (Type or print)	First LAURA	Middle BELL	Last HALL
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB. 18, 1887
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE	10b. KIND OF BUSINESS OR INDUSTRY HOME	11. BIRTHPLACE (County & State, or foreign country) VA.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME ELBERT P. ROBERTS	14. MOTHER'S MAIDEN NAME DIANA HALL	Address ROBERT G. HALL, HAVRE DE GRACE, MD.	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>	16. SOCIAL SECURITY NO.	17. INFORMANT	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X Conditions, if any, which give rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e) Cerebral Hemorrhage Hypertension - Arterio sclerosis	INTERVAL BETWEEN ONSET AND DEATH
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20c. TIME OF INJURY Hour a.m. p.m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 10-1-60, 19, to 12-5, 1961, that (I) (we) last saw the deceased alive on 10-15, 1961, and that death occurred at 10 A.M. from the causes and on the date stated above.		22b. DATE SIGNED	
22e. SIGNATURE 	M.D.	ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type)	22d. ADDRESS		

23a. BURIAL, CREMATION, REMOVAL, (Specify) BURIAL	23b. DATE THEREOF DEC. 20, 1961	23c. NAME OF CEMETERY OR CREMATORIAL BELAIR MEMORIAL GARDENS	23d. LOCATION (City, town or county) HARFORD CO. MO.	(State)
24. FUNERAL DIRECTOR'S SIGNATURE R. Madison Mitchell, HAVRE OF GRACE	ADDRESS	NO. 100	25a. REC'D BY REGISTRAR DEC 20 '61	25b. REGISTRAR'S SIGNATURE Clifton S. Kline

1000
1000

M

M

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
 ISM 9/59

13996

CERTIFICATE OF DEATH

13965

1. PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
<i>Havre de Grace</i>		15 DAYS		a. STATE	b. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
Cameron L. Harkins		Thomas Bridge Rd			
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH
M		W		L.	12 6 1961
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday) yrs.
				FEB. 11, 1882	79
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Retired		FARMING		Md USA	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
William Thomas Harkins		Emma Robison		USA	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT	
		—		CLAUDE E. HARKINS, STREET, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		fresh myocardial infarction 1 day			
420.1 DUE TO					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		Coronary thrombosis 1 day.			
DUE TO					
(c) A. S. C. V. D.					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
Active pulmonary tuberculosis; Pulmonary infarction, pneumonia, profuse amount of rectal bleeding from hemorrhoids.					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		Bleeding from hemorrhoids.	
002.1					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
				Dec. 6th, 1961, to Dec. 6th, 1961	
21. I certify that (I) (this hospital) attended the deceased from Dec. 6th, 1961, and that death occurred at 4 P.M., from the causes and on the date stated above.					
22a. SIGNATURE		ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
Edward C. Loo, M.D.				12/6/61	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS		22b. DATE SIGNED	
Edward C. Loo, M.D.		Havre de Grace, Md.		12/6/61	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORIAL	
BURIAL		12-9-61		EMORY	
24. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		23d. LOCATION (City, town, or county) (State)	
John H. Harkins, DELTA, PA.				STREET, HARFORD Co., MD.	
25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		DATE	
				DEC 11 '61	

60011

HEADS OF THE UNITED STATES

30001

M

FOR STATE
HEALTH DEPT.

Please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13997 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13966

1. PLACE OF DEATH

a. COUNTY

Harford

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Havre de Grace

c. LENGTH OF STAY IN 1b

R 9 2

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

R 9 2

3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

4. DATE
OF
DEATH

Month

Day

Year

Johnny George Hubble

December 16 1961

5. SEX

6. COLOR OR RACE

Male

White

7. MARRIED NEVER MARRIED

WIDOWED DIVORCED

8. DATE OF BIRTH

Sept. 20, 1898

9. AGE (In years
last birthday) IF UNDER 1 YEAR
63 yrs. Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Farmer

10b. KIND OF BUSINESS OR INDUSTRY

Farm

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Kent Hubble

14. MOTHER'S MAIDEN NAME

Amanda Victoria Purcell

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes, give rank or date of service)

No

16. SOCIAL SECURITY NO. 17. INFORMANT

220-05-3402 Lenora R. Hubble, Havre de Grace

Address R.D. 2

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

443X

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

(c)

INTERVAL BETWEEN
ONSET AND DEATH

-

Hypertension & Disease

MEDICAL CERTIFICATION

19. WAS AUTOPSY PERFORMED?

YES NO

20e. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

Diabetes mellitus

20c. TIME OF INJURY Month, Day, Year
Hour a.m.
p.m.

19

20d. INJURY OCCURRED
While Not While
at work at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

2df. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion
death resulted from: Natural causes Accident Suicide Homicide Undetermined manner

ACTUAL
SIGNATURE

Gerald C Palmer

CHIEF MEDICAL EXAMINER

Beltair, Md.

DATE SIGNED

EXAMINER'S
NAME (Type)

Gerald C Palmer - M.D.

ASSISTANT MEDICAL EXAMINER

John G. Tarrying

12-10-61

DEPUTY MEDICAL EXAMINER

Address (Street, city, town, or county)

22a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

22b. DATE THEREOF

12/18/61

22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS

Mt. Zion Cemetery

22d. LOCATION (City, town, or country) (State)

R.D.

, Bel Air, Maryland

23. FUNERAL DIRECTOR

John G. Tarrying

24a. REC'D BY REGISTRAR

Tarrying Funeral Home

24b. REGISTRAR'S SIGNATURE

Albert S. Kraus

DATE DEC 21 '61

Sept

2000 ft

65° A

68° A

Normal - about 3 broad bands

small & compact

thin

in other

~ 100 ft

10-21

100 ft

100 ft

100 ft

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13993

CERTIFICATE OF DEATH

Reg. Dist. No. 13967

1. PLACE OF DEATH o. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Fallston	c. LENGTH OF STAY IN lb 9 years	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Fallston X	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Reckord Road	d. STREET ADDRESS Reckord Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Otto	First	Middle Walter	4. DATE OF DEATH December 2, 1961
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH May 14, 1894
8. AGE (In years lost birthday) 67 yrs.		9. IF UNDER 1 YEAR Months Days	10. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steam Fitter		10b. KIND OF BUSINESS OR INDUSTRY Shipyard	11. BIRTHPLACE (State or foreign country) Germany
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Emil Hyne	
14. MOTHER'S MAIDEN NAME Freida Prussia		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, or unknown) No	
16. SOCIAL SECURITY NO. 215-05-0808		17. INFORMANT (Wife) Mrs. Madeline G. Hyne	Address Reckord Road Hydes, Maryland
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 204.4 DUE TO CARDIO-RESP FAILURE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) CONGESTIVE HEART FAILURE - A.S.C.V.D. 4 MO. } (c) LEUKEMIA. 1½ YRS		INTERVAL BETWEEN ONSET AND DEATH 4 DAYS.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) INJURIES IN AUTO ACCIDENT - MAY 1961 - BROKEN HIP.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) AUTO COLLISION.	
20c. TIME OF INJURY Hour a. m. p. m. MAY 19 61	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from alive on <u>1 DEC 1961</u> , and that death occurred at <u>11 P.M.</u>		Nov 1961, that I last saw the deceased from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>401 Madeline St. Bel Air</u> DATE SIGNED <u>Feb 61</u>	
ACTUAL SIGNATURE <u>H. P. Sidwell</u> PHYSICIAN'S NAME (Type) <u>H. P. Sidwell, M.D.</u>	M.D. <u>Franklin St., Bel Air, Maryland</u>		
22o. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Dec. 5, 1961	22c. NAME OF CEMETERY OR CREMATORIAL Bel Air Memorial Gardens	22d. LOCATION (City, town, or county) Bel Air, Harf., Md. (State)
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph W. Foster</u>		ADDRESS <u>W. Broadway & Williams Bel Air, Maryland</u>	24a. REC'D BY REGISTRAR <u>DEC 5 '61</u> DATE
			24b. REGISTRAR'S SIGNATURE <u>Arthur S. Anna</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 To be retained by the hospital or attending physician.
 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

M

Please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to FUNERAL DIRECTOR. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-1. Page 5 may be retained for your files.

V.S. A15ME
5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13995

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13968

1. PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)		b. STATE		Md		b. COUNTY		Harford			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		Bel Air		c. LENGTH OF STAY IN 1b		6 yrs.,		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		Bel Air		Rural			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		Wheel Road		d. STREET ADDRESS		Wheel Road		e. IS RESIDENCE ON A FARM?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First Raymond		Middle Kyle		Last Isom		4. DATE OF DEATH		Month December		Day 29		Year 1961	
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
M		W		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Mar. 22, 1904		57 yrs.		Months		Days		Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?									
Laborer		Landscaping		Virginia		U.S.A.,									
13. FATHER'S NAME		Thomas L. Isom		14. MOTHER'S MAIDEN NAME		Hattie Thorn									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank or date of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address									
no		212-32-4368		Mrs. Lillian R. Isom, Bel Air R.D. #3 Md.,											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		Carcinoma lung		INTERVAL BETWEEN ONSET AND DEATH									
163X		DUE TO													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)													
DUE TO															
(c)															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)															
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)													
20c. TIME OF INJURY		Month, Day, Year		20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)			
Hour a.m. p.m.		19		While at work <input type="checkbox"/>		Not While at work <input type="checkbox"/>									
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE		Gerald C Palmer						CHIEF MEDICAL EXAMINER <input type="checkbox"/>		Bel Air, Md.					
EXAMINER'S NAME (Type)		Gerald C Palmer						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>						DATE SIGNED	
22e. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS		22d. LOCATION (City, town, or county)		24e. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE					
Burial		Dec. 23, 1961		Bel Air Memorial Gardens		Bel Air, Harford, Md.,		DATE DEC 26 '61		Arthur S. Trahan					
23. FUNERAL DIRECTOR		Howard K. McComas & Son		Abingdon, Md.,											

8000

Answers

1. 1.

2. 1921

2.

Answers

Initial

particular

total

more than

most of all

the most important thing about

the most important thing about

Answers

20-10-1979

Answers to questions in the test

Answers

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be submitted within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

14000

CERTIFICATE OF DEATH

13969

Reg. Dist. No.

1. PLACE OF DEATH

COUNTY	Baltimore	Harford	MARYLAND
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (In this place)		
TOWN	Bel-Air		
HOSPITAL OR INSTITUTION OR STREET ADDRESS	35 yrs.		
137 Aliceanne Street			

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE	Maryland	COUNTY	Baltimore	Harford
CITY (If outside corporate limits, write RURAL and give nearest town)				
TOWN	Bel-Air			
STREET ADDRESS	137 Aliceanne Street			
(If rural give location)				

**3. NAME OF
DECEASED
(Type or Print)**

(First) ALBERTA

(Middle)

(Last) JOHNSON

4. DATE (Month) (Day) (Year)

DEC 4 1961

5. SEX

F.

6. COLOR OR
RACE

C

7. SINGLE, MARRIED,
WIDOWED, DIVORCED,
(Specify)

Widow

8. DATE OF BIRTH

APR 7, 1878

9. AGE last birthday

83

yrs.

IF UNDER 1 YEAR

Months

Deys

Hours

Min.

10e. USUAL OCCUPATION (Give kind of work
done during most of working life, even if
retired)

Cook

10b. KIND OF BUSINESS
OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Harford Co., Md.

12. CITIZEN OF WHAT
COUNTRY?

U.S.A.

13. FATHER'S NAME

Westcoat

14. MOTHER'S MAIDEN NAME

Augustus Spriggs

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unk.)

(If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.

220-30-2127

17. INFORMANT & ADDRESS

Balto., Md.

Joseph Johnson-2416 Harlem Ave

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

450.0 IMMEDIATE CAUSE

(A)

CARDIO-RESPI. FAILURE

INTERVAL BETWEEN
ONSET AND DEATH

2 DAYS

ANTECEDENT CAUSE(S) DUE TO
DISEASES OR CONDITIONS, IF ANY, (B)
GIVING RISE TO THE ABOVE CAUSE
STATING UNDERLYING CAUSE LAST. DUE TO
(C)

ADVANCED ARTERIOSCLEROSIS

44 YEARS

**II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING DEATH.**

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES NO 21a. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH
(If either, NOTIFY MEDICAL EXAMINER)21b. PLACE (Home, term, factory,
OF INJURY street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (City or town)

(County)

(State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)

21e. INJURY OCCURRED
While Not while
at work at work

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from.....

alive on 4 DEC 1961, to DEC 1961, that I last saw the deceased

and that death occurred at 8:00 P.M. from the causes and on the date stated above.

SIGNATURE

H. M. Adcock

ADDRESS (Street, city, town, state) DATE SIGNED

401 Franklin St. Bel-Air, Md. DEC 1961

23. BURIAL, CREMATION,
REMOVAL (SPECIFY)

Burial

DATE THEREOF

12-8-61

NAME OF CEMETERY OR CREMATORI

Henden Hill

LOCATION (City, town, or county)

(State)

Bel-Air, Md.

24. REC'D BY REGISTRAR

REGISTRAR'S SIGNATURE

Arthur S. Kraus

25. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

George W. Little Bel-Air 230

DATE DEC 11 '61

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14001

CERTIFICATE OF DEATH

13970

1. PLACE OF DEATH a. COUNTY HARFORD		2. USUAL RESIDENCE (Where deceased lived, If institution, residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAURE DE GRACE		c. LENGTH OF STAY IN 1b 3 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) HARFORD Memorial Hosp.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Bridget M		4. DATE OF DEATH Last Johnston Month DECEMBER Day 21 Year 1961	
5. SEX FEMALE		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 12 1887	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (County & State, or foreign country) IRELAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Timothy Bracken		14. MOTHER'S MAIDEN NAME Mary Connolly Belair md.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give rank and dates of service)	
17. INFORMANT Mrs Joseph Leibanger = 304 Lake Side Dr.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (e), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE 490X		INTERVAL BETWEEN ONSET AND DEATH 4 days.	
Conditions, if any, which give rise to immediate cause (e), stating the underlying cause last. } DUE TO } A.S.C.V.D.		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e) Generalized arteriosclerosis + Senility	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. ACCIDENT WAS UNDERLYING CAUSE OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20c. TIME OF INJURY Hour e.m. 19		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Dec 18th, 1961		(County) Dec 21st, 1961	
(State) MD		(State) MD	
21. I certify that (I) (this hospital) attended the deceased from Dec 18th, 1961 to Dec 21st, 1961 , that (I) (we) last saw the deceased alive on Dec 21st, 1961 , and that death occurred at 2 PM , from the causes and on the date stated above.		22b. DATE SIGNED 12/21/61	
22c. PHYSICIAN'S NAME (Type) Edward Loomis		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS Edward Loomis MD Haure de Grace, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF 12/22/1961	
23c. NAME OF CEMETERY OR CREMATORIAL Mt. Calvary Cemetery		23d. LOCATION (City, town or county) Kansas City, Mo.	
24. FUNERAL DIRECTOR'S SIGNATURE John G. Tarras - Aberdeen, Maryland.		ADDRESS DATE DEC 26 '61	
		25a. REC'D BY REGISTRAR DATE	
		25b. REGISTRAR'S SIGNATURE Arthur S. Krause	

200

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 13971

1. PLACE OF DEATH a. COUNTY		14002 Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		d. STATE MD b. COUNTY Harford	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		X c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Shingdon			
3. NAME OF DECEASED (Type or print)		First IVAN	Middle FRANK	Last KLATIL	4. DATE OF DEATH December 21 1961
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH Dec. 3, 1935	
WIDOWED <input type="checkbox"/>		DIVORCED <input type="checkbox"/>		9. AGE (In years last birthday) 26 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY Electronic Technician Electronics		11. BIRTHPLACE (State or foreign country) Czechoslovakia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Aldrich Klatil		14. MOTHER'S MAIDEN NAME Marta Misurcova	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 218-32-6781		17. INFORMANT Aldrich Klatil, Address R.D. 1 Abingdon, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		1 fracture skull			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO (b)			
		DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury In Part I or Part II of Item 18.) A nts accident			
20c. TIME OF INJURY Month, Day, Year Hour AM. 12 - 21 1961 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Edgewood Ha. (County) MD (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> Belvoir, Md. EXAMINER'S NAME (Type) Gerald C Palmer M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <i>Gerald C Palmer</i> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Gerald C Palmer- 19 DATE SIGNED 13-77-61			
22e. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/24/61		22c. NAME OF CEMETERY OR CREMATORIAL St Francis Cemetery Abingdon, Maryland	
22d. LOCATION (City, town, or county)		(State)			
23. FUNERAL DIRECTOR John G. Tarring		ADDRESS Tarring Funeral Home Aberdeen, Md.		24a. REC'D BY REGISTRAR DEC 29 '61	
				24b. REGISTRAR'S SIGNATURE Arthur S. Klaus	

REPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

V.S. A1SM
5M 9/60

2011



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4

TO MEDICAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18													
14003 CERTIFICATE OF DEATH													
1. PLACE OF DEATH a. COUNTY						2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE							
Harford MARYLAND						Maryland b. COUNTY Baltimore ✓							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			c. LENGTH OF STAY IN lb			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			d. STREET ADDRESS				
Rural Bel Air						Hydes.			03x-2				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION			e. LENGTH OF STAY IN lb			d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
Harford Convalescing Home													
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year					
Daisy		A.	Kolk		December	24	19	61					
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH	9. AGE (In years lost birthday) yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	Months	Days	Hours	Min.		
F		W		7-3-1884	77								
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country)			12. CITIZEN OF WHAT COUNTRY?				
Housewife			Home			Washington Co., Md.			U.S.A.				
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME			Address							
Samuel Hoffmaster			Mary Rohrer			Mrs. Howard Tolle, Jr. Box 366, Baldwin, Md.							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO.			17. INFORMANT			INTERVAL BETWEEN ONSET AND DEATH				
No						Mrs. Howard Tolle, Jr. Box 366, Baldwin, Md.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]													
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u>													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) _____ (c) _____													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from <u>12-24</u> , 19 <u>61</u> , to <u>12-24</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>12-24</u> , 19 <u>61</u> , and that death occurred at <u>117</u> M, from the causes and on the date stated above.													
ACTUAL SIGNATURE <u>Gerald E Palmer</u> M.D.													
PHYSICIAN'S NAME (Type) <u>Gerald E Palmer MD</u>													
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			22b. DATE THEREOF 12/28/1961			22c. NAME OF CEMETERY OR CREMATORIUM Fork Methodist Ch. Cem.			22d. LOCATION (City, town, or county) Fork, Maryland			(State)	
23. FUNERAL DIRECTOR'S SIGNATURE H.W.Jenkins & Sons Co.			ADDRESS 4905 York Road Baltimore 12, Md.			24a. REC'D BY REGISTRAR 12/28/61			24b. REGISTRAR'S SIGNATURE Gerald E Palmer				
VS A15 (4) 15M 9/55													

WYOMING STATE GOVERNOR'S OFFICE

CERTIFICATE OF DEATH

2002

DECEASED PERSON	EDWARD RAYMOND HARRIS	DEATH DATE	12/10/2002
SEX	MALE	RACE	WHITE
AGE	65	WEIGHT	175
HEIGHT	5'10"	HAIR COLOR	BLACK
ADDRESS	100 E. 2nd Street, Casper, WY 82601	PHONE NUMBER	(307) 267-4211
CAUSE OF DEATH	Cardiac arrest due to coronary artery disease.		
DEATH CERTIFICATION	Medical Examiner		
DEATH REPORT NUMBER	2002-00000000000000000000000000000000		
ISSUED BY	State of Wyoming Department of Health Division of Public Health Office of the State Health Officer		
ISSUED ON	12/10/2002		
EXPIRATION DATE	12/10/2003		
APPROVED	State Health Officer		
SIGNATURE	John Doe		
STAMP	State of Wyoming Department of Health Division of Public Health Office of the State Health Officer		

1
FOR STATE
HEALTH DEPT.

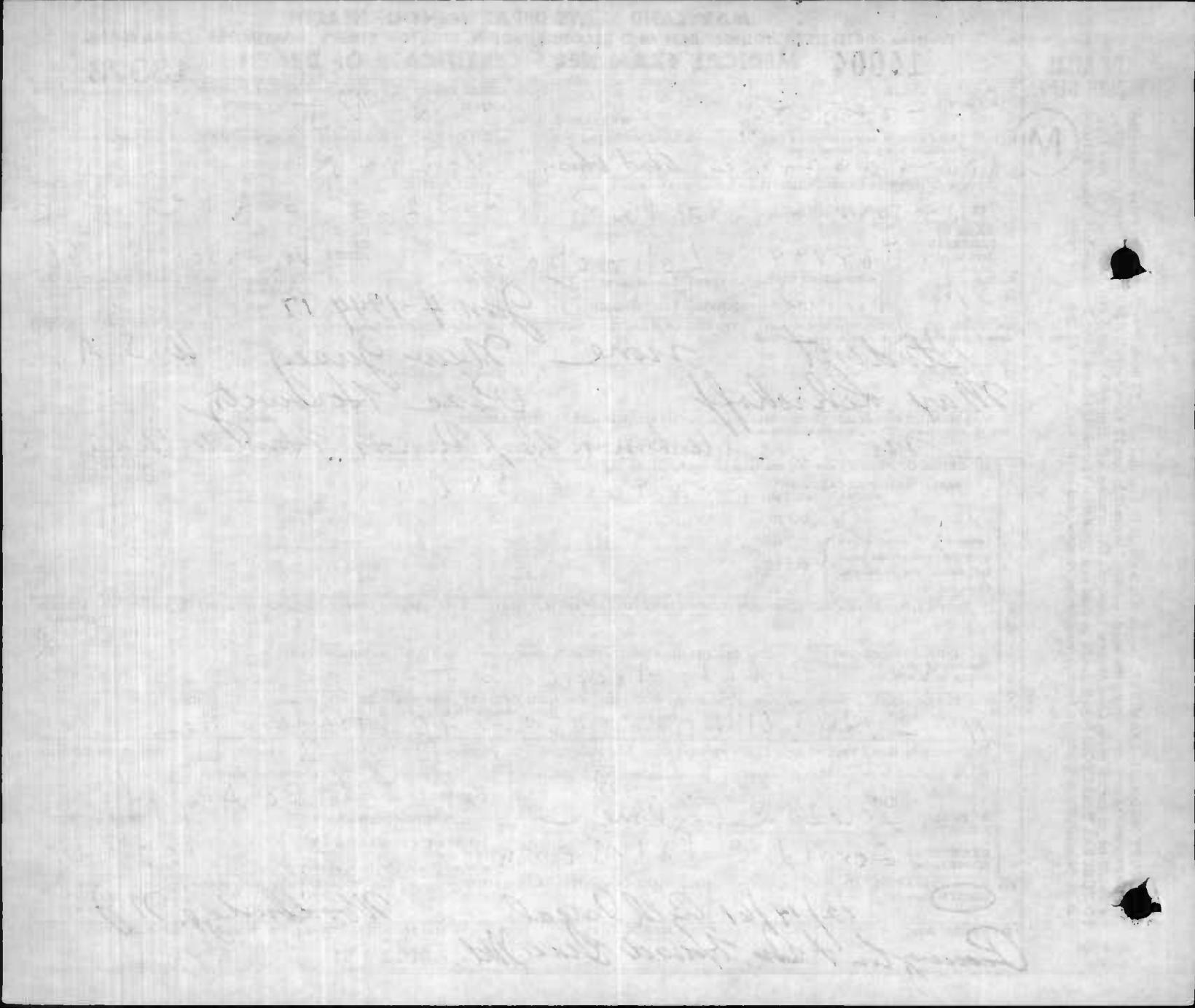
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14004 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13973

1. PLACE OF DEATH a. COUNTY Hartford		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hartford		c. LENGTH OF STAY IN lb about 6 hrs.		a. STATE NJ							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 437-50 Rd Memorial Hospt				b. COUNTY							
3. NAME OF DECEASED (Type or print) Harvey Lehrhoff		First	Middle	Last	4. DATE OF DEATH December 13 1961						
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 4 - 1944		9. AGE (In years last birthday) 17 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) New Jersey		12. CITIZEN OF WHAT COUNTRY U.S.A.					
13. FATHER'S NAME Max Lehrhoff		14. MOTHER'S MAIDEN NAME Rose Horowitz		Address							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (e), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fracture SK n 11		DUE TO 825 X (b)		DUE TO (c)		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20e. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH Auto Accident		20f. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.) 0715 Route 40		20g. (City or town) Aberdeen		(County) Ha		(State) Md.			
20c. TIME OF INJURY Month, Day, Year Hour e.m. 12/13 1961		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.) 0715 Route 40		20f. (City or town) Aberdeen		(County) Ha		(State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> Gerald C Palmer, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 12-13-61					
ACTUAL SIGNATURE Gerald C Palmer		M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county) Woodbridge N.J.					
EXAMINER'S NAME (Type) Gerald C Palmer, M.D.											
22e. BURIAL OR CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 12/14/61		22c. NAME OF CEMETERY OR CREMATOR Y Beth Israel		22d. LOCATION (City, town, or country) Woodbridge N.J.					
22e. BURIAL OR CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 12/14/61		22c. NAME OF CEMETERY OR CREMATOR Y Beth Israel		22d. LOCATION (City, town, or country) Woodbridge N.J.					
23. FUNERAL DIRECTOR Pennington & Son, Hanover Place, Md.		ADDRESS		24a. REC'D BY REGISTRAR REC 20 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas					

PLEAS E EXECUTE THE CERTIFICATE, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to FUNERAL DIRECTOR: Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14005

13971

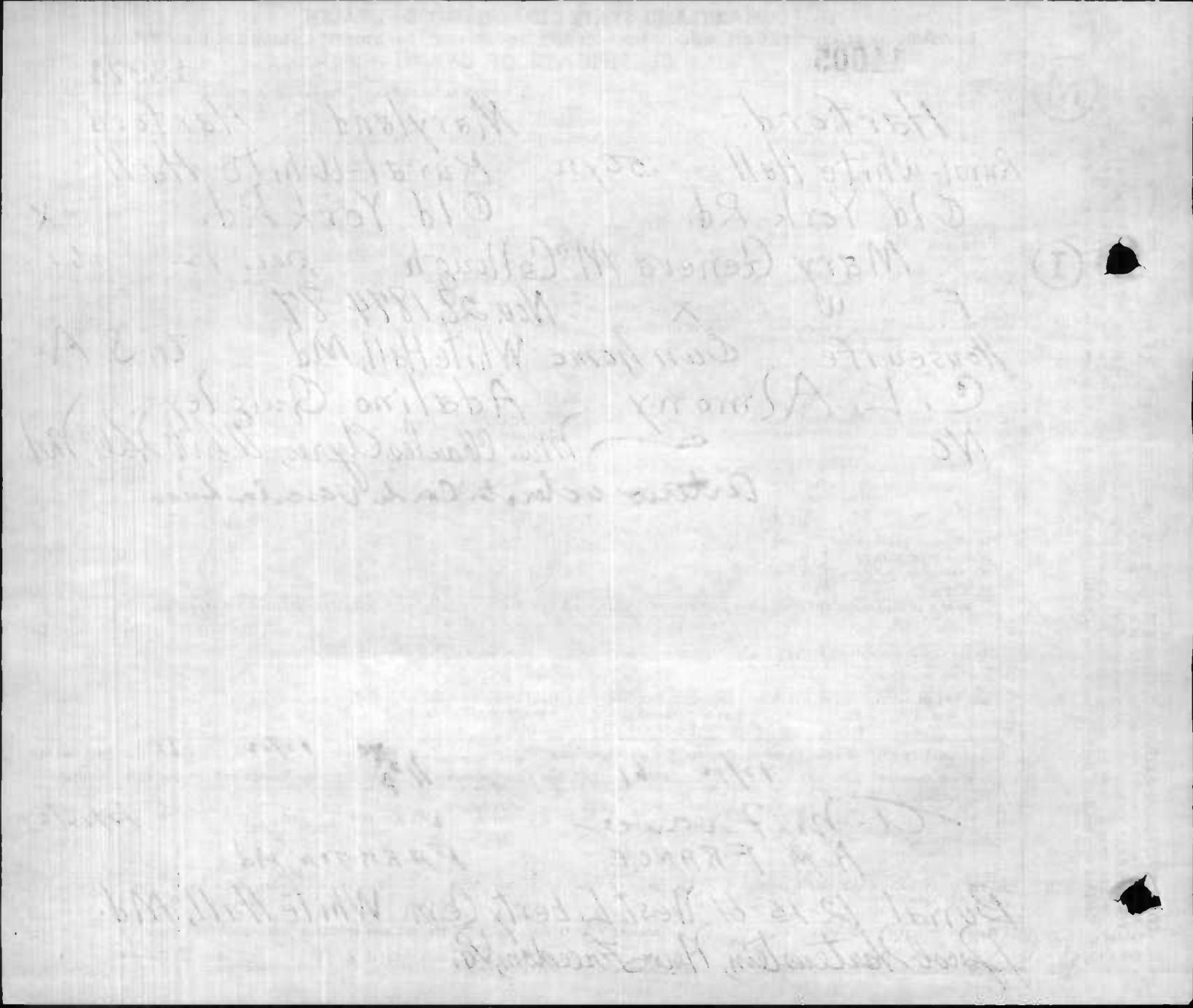
CERTIFICATE OF DEATH

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Harford.		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-White Hall		b. COUNTY Harford.	
c. LENGTH OF STAY IN lb 50 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-White Hall	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Old York Rd.		d. STREET ADDRESS Old York Rd.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Mary Geneva McCollough		First	Middle
4. DATE OF DEATH Dec. 12 1961		Last	Month Day Year
5. SEX F		6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH Nov. 28 1874		9. AGE (In years last birthday) 87 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home	
11. BIRTHPLACE (County & State, or foreign country) White Hall, Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME C. L. Almony		14. MOTHER'S MAIDEN NAME Adeline Quigley	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <input type="checkbox"/> (If yes give war or date of service) No		16. SOCIAL SECURITY NO. Address	
17. INFORMANT Mrs. Charles Ayres, White Hall, Md.		18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) Arterio sclerotic Cardi Vascular disease	
DUE TO 422.1 Conditions, if any, which give rise to immediate cause (e), stating the underlying cause last. (b)		INTERVAL BETWEEN ONSET AND DEATH 	
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)			
20e. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II if item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Parkton, Md.
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 1970 , to 12/12 1961 , that (I) (we) last saw the deceased alive on 12/12 1961 , and that death occurred 11:30 P.M. from the causes and on the date stated above.			
22e. SIGNATURE A. M. France		ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>
22c. PHYSICIAN'S NAME (Type) A. M. FRANCE		22d. ADDRESS Parkton, Md.	
22e. DATE SIGNED 12/14/61			

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 12-15-61	23c. NAME OF CEMETERY OR CREMATORIUM West Liberty Cem. White Hall, Md.	23d. LOCATION (City, town or county) (State)
24. FUNERAL DIRECTOR'S SIGNATURE Jacob Hartenstein, New Freedom, Pa.		ADDRESS	
25e. REC'D BY REGISTRAR DATE DEC 18 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	



1
FOR STATE
HEALTH DEPT.

Please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to Funeral Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14006

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13975

1. PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)			
Harrowd				a. STATE	b. COUNTY		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
Havre de Grace		90A		Bel Air			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				d. STREET ADDRESS			
Harrowd Memorial Hospital				RDI			
3. NAME OF DECEASED (Type in full)		First	Middle	4. DATE OF DEATH	Month Day Year		
IDA Gertrude McCoy				December - 17 1961			
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday) IF UNDER 1 YEAR yrs. Months Days 78 yrs.	10. BIRTHPLACE (State or foreign country)	11. CITIZEN OF WHAT COUNTRY?
F		W		4-21-1883		Raleigh N.C.	U.S.A.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Housewife		Home					
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]	
Henry McCoy		Anna Dean McCoy		no		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) 332X	
Conditions, if any, which gave rise to immediate causa (e), stating the underlying cause last.		(b)		DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
				DUE TO			
		(c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)					
20c. TIME OF INJURY Hour e.m. p.m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Bel Air	(County) Md.	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
ACTUAL SIGNATURE		Gerald E. Palmer		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		12-18-61	
EXAMINER'S NAME (Type)		Gertrude McCoy - MD		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORI	22d. LOCATION (City, town, or country)			(State)
Burial		12/20/61	Bellair Memorial Garden	Bell Air			Md.
23. FUNERAL DIRECTOR		ADDRESS		24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE		
Charles E. Kurtz		Garretttsville Md.		DEC 21 '61	Arthur S. Krause		

2001

M

1

100

100

100 m

100 m

100 m

100 m

100 m

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14007

13976

CERTIFICATE OF DEATH

1. PLACE OF DEATH

a. COUNTY

Harford

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Havre-de-Grace

c. LENGTH OF STAY IN lb

6 days.

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Harford Memorial Hospital

3. NAME OF

(Type or print)

First

Middle

Last

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED

 NEVER MARRIED
 WIDOWED
 DIVORCED

8. DATE OF BIRTH

Jan. 12, 1908

9. AGE (In years last birthday)

53 yrs.

10. IF UNDER 1 YEAR

Months Days

11. IF UNDER 24 HRS.

Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Mushroom Worker

10b. KIND OF BUSINESS OR INDUSTRY

Grower

11. BIRTHPLACE (County & State, or foreign country)

Va.

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

John P. McGlothlin

14. MOTHER'S MAIDEN NAME

Mellie McGlothlin

Address Conowingo, Md.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank or dates of service)

No

16. SOCIAL SECURITY NO.

213-05-4365

17. INFORMANT

Carrie McGlothlin (wife)

18. CAUSE OF DEATH (Enter only one cause per line for (e), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

600.1

Septicemia

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

DUE TO

(b)

DUE TO

(c)

Perinephric abscess

INTERVAL BETWEEN
ONSET AND DEATH

6 days

10 days

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year

Hour a.m.

p.m.

19

20d. INJURY OCCURRED
While Not While
at work at work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from 8, 1961, to 12/2, 1961, that (I) (we) last
saw the deceased alive on 12/2, 1961, and that death occurred at 39 M, from the causes and on the date stated above.

22e. SIGNATURE

Neil R Taylor M.D.

ATTENDING PHYS.

MED. DIRECTOR

STAFF PHYS.

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type)

Neil R Taylor, M.D.

22d. ADDRESS

Rising Sun Maryland

23a. BURIAL OR CREMATION (Specify)

Burial

23b. DATE THEREOF

12-6-1961

23c. NAME OF CEMETERY OR CREMATORIAL

harmony Chapel

23d. LOCATION (City, town or county)

(State)

Liberty Grove, Md.

24. FUNERAL DIRECTOR'S SIGNATURE

Lev A. Patterson & Son,

ADDRESS

Perryville, Md.

25e. REC'D BY REGISTRAR DATE

DEC 6 '61

25b. REGISTRAR'S SIGNATURE

Arthur S. Thorne

101

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

14008

Items 3 & 16 Film G302 12/11/61

13977

1. PLACE OF DEATH

a. COUNTY

Harford

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Harre-de-Grace

c. LENGTH OF STAY IN lb

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Harford Memorial Hospital

3. NAME OF DECEASED
(Type or print)

First

Middle

Last

4. DATE OF DEATH

Month

Day

Year

12

3

1961

5. SEX

6. COLOR OR RACE

Female White

7. MARRIED

 NEVER MARRIED WIDOWED DIVORCED

8. DATE OF BIRTH

Feb. 20, 1926

9. AGE (In years last birthday) IF UNDER 1 YEAR
35 yrs. Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

House-wife

10b. KIND OF BUSINESS OR INDUSTRY

Own Home

11. BIRTHPLACE (County & State, or foreign country)

Md.

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

OTho Mount

14. MOTHER'S MAIDEN NAME

Mary Keesey

Address

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

220-18-5492

17. INFORMANT

Peter P. Mc Kay, Perryville, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY,
IMMEDIATE CAUSE (a)592X
Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

DUE TO

(b)

DUE TO

(c)

Uremia

Chronic nephritis

Toxemia of pregnancy

INTERVAL BETWEEN
ONSET AND DEATH

3 month

7 years

7 years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)

20a. ACCIDENT WAS UNDERLYING

OR CONTRIBUTING

CAUSE OF DEATH
(If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY

Month, Day, Year

Hour

a.m.

p.m.

19

20d. INJURY OCCURRED

While
at workNot While
at work20a. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from July 1st, 1956 to Dec. 3rd, 1961, that (I) (we) last saw the deceased alive on Dec 3rd, 1961, and that death occurred at 3:45 P.M. from the causes and on the date stated above.

22a. SIGNATURE

Edward C. Loom, M.D.

ATTENDING
PHYS.MED.
DIRECTORSTAFF
PHYS.

22d. ADDRESS

22b. DATE
SIGNED

12/4/61

23a. BURIAL, CREMATION,
REMOVAL (Specify)

Burial

23b. DATE THEREOF

12-7-1961

23c. NAME OF CEMETERY OR CREMATORIAL

St Mark's Cemetery

23d. LOCATION (City, town or county)

Perryville, Md. Rural

(State)

24. FUNERAL DIRECTOR'S SIGNATURE

Jesse A. Patterson & Son,

ADDRESS

Perryville, Md.

25a. REC'D BY REGISTRAR

DEC 6 '61

25b. REGISTRAR'S SIGNATURE

Arthur S. Krause

2001

(M)

28 3190.03.002

1990.03.002

2001.03.002

C1

1990.03.002

1990.03.002

FOR STATE
HEALTH DEPT.

If any delay is necessary,
please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14684

1. PLACE OF DEATH

a. COUNTY

Harfard

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Near Havre de Grace

c. LENGTH OF STAY IN 1b

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

ROUTE #7

3. NAME OF
DECEASED
(Type or print)

First

Middle

Robert

Ross Mitchell

5. SEX

6. COLOR OR RACE

Male

white

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Laborer Skyway Diner

WIDOWED

DIVORCED

7. MARRIED

NEVER MARRIED

X

8. DATE OF BIRTH

2-27-1942

11. BIRTHPLACE (State or foreign country)

Maryland

14. MOTHER'S MAIDEN NAME

Lillie Louise Thompson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or defense of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

No

18. CAUSE OF DEATH (Enter only one cause per line for (e), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (e)

DUE TO

Conditions, if any, which
give rise to immediate cause
(e), stating the underlying
cause last.

(b)

DUE TO

(c)

Accidental drowned in Chesapeake Bay

near Havre de Grace, Maryland

INTERVAL BETWEEN
ONSET AND DEATH

0
MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS
PRIMARY or CONTRIBUTING CAUSE OF DEATH

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

2d. TIME OF INJURY Month, Day, Year
Hour e.m. 19
p.m.

2d. INJURY OCCURRED
While at work Not While at work

2d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and in my opinion death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined manner

ACTUAL
SIGNATURE

EXAMINER'S
NAME (Type)

R.C. Dodson

22b. DATE THEREOF

Burial 4-3-1962

22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS

Rising Sun, Md

Angel Hill

23. FUNERAL DIRECTOR

R. Madison Mitchell

R. Madison Mitchell

Havre de Grace, Maryland

Address (Street, city, town, or county)

22d. LOCATION (City, town, or country) (State)

Havre de Grace, Harford Co., Md.

24b. REC'D BY REGISTRAR

Cirrhous S. Thomas

DATE APR 4 '62

M



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

14009

13978

1 \$ M 71 I 0 1		1. PLACE OF DEATH a. COUNTY <i>Hanford</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Havre de Grace</i> c. LENGTH OF STAY IN 1b <i>1 day</i> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Hanford Memorial Hosp</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Hanford</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Havre de Grace</i> d. STREET ADDRESS <i>Blenheim Rd, Box 53</i>	
		3. NAME OF DECEASED (Type or print) <i>Elizabeth F. Osborn</i>		4. DATE OF DEATH Month Day Year <i>12 12 1961</i>	
		5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>Aug. 2nd 1882</i>
		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Never worked.</i>	
		11. BIRTHPLACE (State or foreign country) <i>Md</i>		9. AGE (In years last birthday) yrs. <i>99</i>	
		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
13. FATHER'S NAME <i>J Henry Osborn</i>		14. MOTHER'S MAIDEN NAME <i>Frances Fletcher</i>		Address	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT <i>Eazy S. Osborn - Havre de Grace #1-rev.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Chronic Cardiac Decompensation</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>422.1</i> (b) DUE TO <i>Arteriosclerotic Cardiovascular Disease</i> (c)				INTERVAL BETWEEN ONSET AND DEATH <i>7 years.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month Day Year Hour a. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>Dec. 6th, 1961</i> to <i>Dec. 12th, 1961</i> , that (I) (we) last saw the deceased alive on <i>Dec. 12th, 1961</i> and that death occurred at <i>10 PM</i> , from the causes and on the date stated above.					
22a. SIGNATURE <i>Edward C. Loo, M.D.</i>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>12/12/61</i>	
22c. PHYSICIAN'S NAME (Type) <i>Edward C. Loo, M.D.</i>		22d. ADDRESS <i>Havre de Grace, Md.</i>			
23a. BURIAL, CREMATION OR REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>12/15/1961</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Grove Presbyterian</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>John G. Tarras - aberdeen. revd.</i>		ADDRESS		25a. REC'D BY REGISTRAR DATE <i>DEC 21 '61</i>	
				25b. REGISTRAR'S SIGNATURE <i>Carroll S. Kimes</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

2001

TO A HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13979

1. PLACE OF DEATH a. COUNTY <i>Harford</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Harve de Grace</i>		c. LENGTH OF STAY IN 1b <i>22 days</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Harford Memorial Hospital</i>		e. STREET ADDRESS <i>1862 Churchville Rd.</i>	
3. NAME OF DECEASED (Type or print)		First <i>Zula</i>	Middle <i>Elizabeth</i>
		Last <i>Peters</i>	4. DATE OF DEATH <i>Dec. 18</i>
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>JANUARY 15, 1881</i>		9. AGE (In years lost birthday) <i>80 yrs.</i>	10. IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min. <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housework</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Housewife</i>	11. BIRTHPLACE (State or foreign country) <i>U.S.A - Virginia</i>
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>George Thomas</i>	
14. MOTHER'S MAIDEN NAME <i>Betty Reid</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	
16. SOCIAL SECURITY NO. <i>—</i>		17. INFORMANT (Son) <i>Mr Henry M. Peters</i>	18. ADDRESS <i>129 N. Lynbrook Road, Bel Air, Maryland</i>
19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Arrest.</i>		INTERVAL BETWEEN ONSET AND DEATH	
450.0 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <i>Generalized Arteriosclerosis</i>		DUE TO	
(c) <i>—</i>		DUE TO	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) <i>Bel Air</i>		(State) <i>Maryland</i>	
21. I certify that (I) (this hospital) attended the deceased from <i>Dec. 8</i> , 1961, to <i>Dec. 18</i> , 1961, that (I) (we) last saw the deceased alive on <i>12-16</i> , 1961, and that death occurred at <i>3 P.M.</i> from the causes and on the date stated above.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <i>Frank J. Hauber</i>		M.D. <input type="checkbox"/> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22d. ADDRESS
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>DEC. 20, 1961</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Mt. Zion Cemetery</i>
23d. LOCATION (City, town, or county) <i>Rural Bel Air, Harford, Maryland</i>		(State)	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Joseph W. Foster</i>		25a. ADDRESS <i>W. Broadway and Williams St. Bel Air, Maryland</i>	25b. REC'D BY REGISTRAR DATE <i>DEC 21 '61</i>
		25b. REGISTRAR'S SIGNATURE <i>Arthur L. Kraus</i>	

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

14011

13980

1. PLACE OF DEATH

a. COUNTY

Harford Maryland

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Harde Grace 73 yrs.

c. LENGTH OF STAY IN lb

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

3. NAME OF
DECEASED
(Type or print)

First

Middle

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED

NEVER MARRIED

WIDOWED

DIVORCED

b. DATE OF BIRTH

1/10/1889

4. DATE
OF
DEATH

Month

Dey

Year

12/10/61

19

9. AGE (In years
last birthday)92
yrs.

IF UNDER 1 YEAR

Months

IF UNDER 24 HRS.

Hours

Min.

10e. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Retired

10b. KIND OF BUSINESS OR INDUSTRY

Penn. Railroads

11. BIRTHPLACE (County & State, or foreign country)

Harde Grace, Md.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Wm. H. Poplar

14. MOTHER'S MAIDEN NAME

Annie Murray

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown. If yes give war ordeles of service)

Unknown

16. SOCIAL SECURITY NO.

Unknown

17. INFORMANT

Violet N. Poplar 401 S. Washington Harde Grace, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

422.1

DUE TO

Conditions, if any, which
give rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

(c)

Cardio-Vascular Heart Disease

INTERVAL BETWEEN
ONSET AND DEATH

5 years

MEDICAL CERTIFICATION

20e. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

2db. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)

20c. TIME OF INJURY Month, Dey, Year
Hour e.m. While at work
p.m. 19 Not While at work2d. INJURY OCCURRED
While Not While
at work at work2d. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

2d. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from May 1960 to 12-9-61, that (I) (we) last
saw the deceased alive on 12-4-1961, and that death occurred at 3rd and M, from the causes and on the date stated above.

22e. SIGNATURE

CUNTH D. HIRSCH

M.D.

ATTENDING
PHYS.MED.
DIRECTORSTAFF
PHYS.22b. DATE
SIGNED
12-11-6122c. PHYSICIAN'S
NAME (Type)

CUNTH D. HIRSCH

22d. ADDRESS

421 CONGRESS AV. HARVE DEGRACE, MD.

23e. BURIAL/CREMATION
REMOVAL (Specify)

23b. DATE THEREOF

23c. NAME OF CEMETERY OR CREMATORIUM

23d. LOCATION (City, town or county)

(State)

24. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

25a. REC'D BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

DATE DEC 14 '61

M



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14012

CERTIFICATE OF DEATH

Reg. Dist. No. 13981

1. PLACE OF DEATH a. COUNTY Harford		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bel Air		c. LENGTH OF STAY IN 1b 14 yrs.,	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		32 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bel Air	
3. NAME OF DECEASED (Type or print) Arthur		First W.	Middle Possehl
4. DATE OF DEATH Dec. 5 1961	Month Dec.	Day 5	Year 1961
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Apr. 25, 1866
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cutter		10b. KIND OF BUSINESS OR INDUSTRY U.S. Govt.,	11. BIRTHPLACE (State or foreign country) London, England.
13. FATHER'S NAME August Possehl		14. MOTHER'S MAIDEN NAME - Wilkinson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 198-05-0520 A	17. INFORMANT Mrs. Edward H. Kerns, Bel Air Maryland
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 330X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 18 days	
Cerebral Thrombosis		??	
Cerebral arteriosclerosis		??	
Generalized arteriosclerosis -			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Nov. 1, 1961 , to Dec. 5, 1961 , that I last saw the deceased alive on Dec. 5, 1961 , and that death occurred at 29. M , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 1265 Main	
ACTUAL SIGNATURE Charles Richardson, Jr.		DATE SIGNED Dec. 5, 1961	
PHYSICIAN'S NAME (Type) Charles Richardson, Jr.,		Bel Air Maryland	
22o. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 7, 1961	22c. NAME OF CEMETERY OR CREMATORIAL Hillside
22d. LOCATION (City, town, or county) Roslyn		(State) Philadelphia, Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE Howard K. McComas & Son		24a. REC'D BY REGISTRAR DEC 7 '61	24b. REGISTRAR'S SIGNATURE Charles S. Kraus
ADDRESS Abingdon, Md.,			

MARYLAND STATE DEPARTMENT OF HEALTH - SANITATION

CERTIFICATE OF DOCTOR

100-1

MD 100-1

EXAMINER
H. H. HANSONEXAMINER
H. H. HANSONEXAMINER
H. H. HANSON

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14013

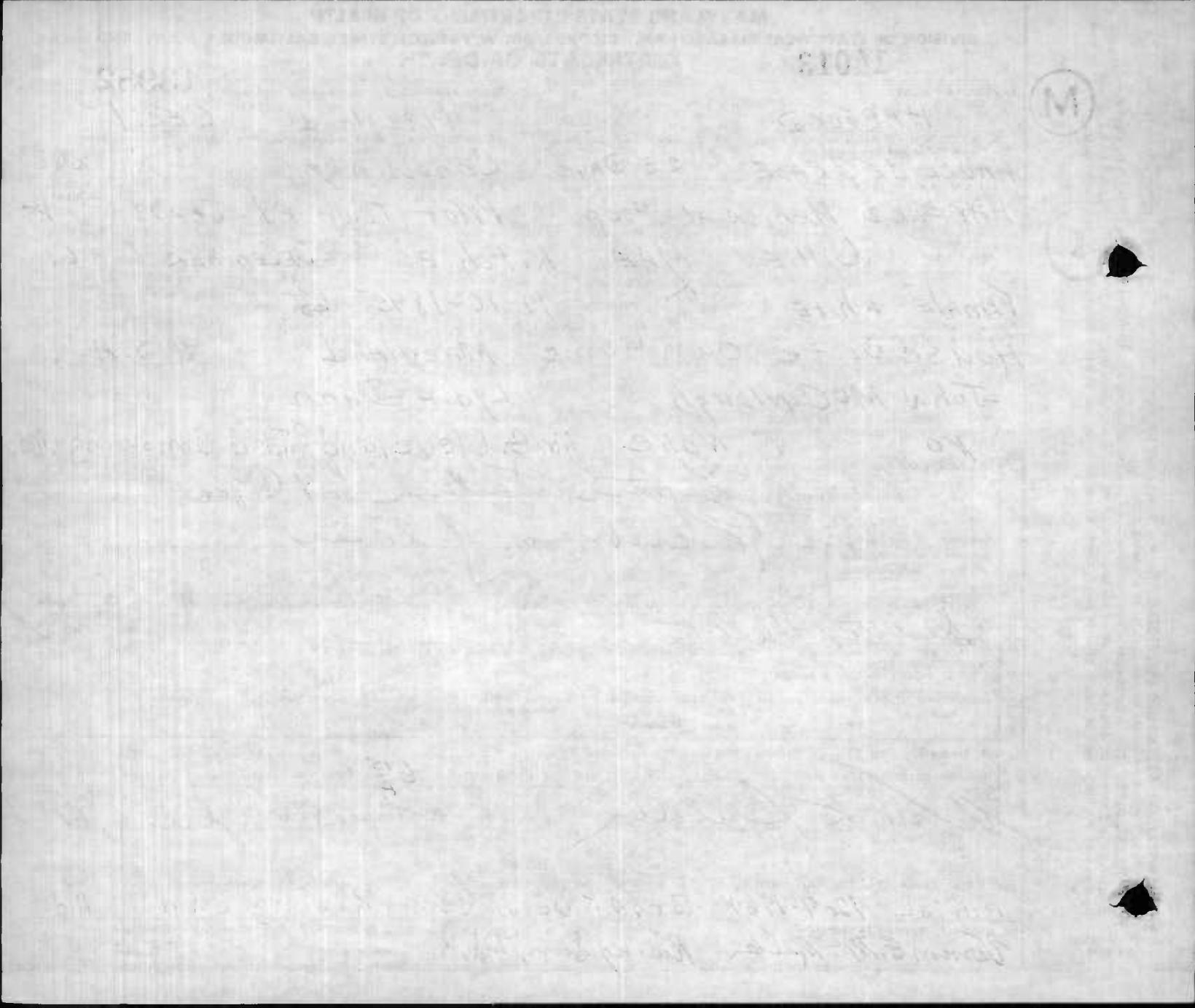
CERTIFICATE OF DEATH

13982

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY HARFORD		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE Maryland		b. COUNTY CECIL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAURE DE GRACE		c. LENGTH OF STAY IN 1b 28 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Conowingo		d. STREET ADDRESS Pilot Town Rd - Rt. 222	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) HARFORD MEMORIAL Hosp.				e. DATE OF DEATH DECEMBER 6 1961		a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED First LILLIE Middle MAE Last Ritchie				f. DATE OF BIRTH 12-10-1895		g. AGE (In years last birthday) 65 yrs.	
3. NAME OF DECEASED (Type or print)				h. DATE OF BIRTH		i. IF UNDER 1 YEAR Months Days Hours Min.	
4. SEX FEMALE		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		j. IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own Home		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John McCullough				14. MOTHER'S MAIDEN NAME Lydia Dunn			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mr. G. Cleveland Ritchie		Address Conowingo, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) S81.0 DUE TO Septic Failure Post Oper.						INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Cirrhosis of liver							
(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes Mellitus							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from....., 19....., to....., 19....., that (I) (we) last saw the deceased alive on....., 19....., and that death occurred at 6:15 A.M. from the causes and on the date stated above.							
22a. SIGNATURE M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) Vernon E. McMillan		22d. ADDRESS Rising Sun, Md.		22e. DATE SIGNED Dec 6, '61			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-9-1961		23c. NAME OF CEMETERY OR CREMATORIUM Brookview Cem. Rising Sun		23d. LOCATION (City, town or county) (State) Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Vernon E. McMillan		ADDRESS Rising Sun, Md.		25a. REC'D BY REGISTRAR DEC 11 '61		25b. REGISTRAR'S SIGNATURE Arthur E. Kline	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14014

CERTIFICATE OF DEATH

13983

1. PLACE OF DEATH

a. COUNTY

HARFORD

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

HAURE de Grace

c. LENGTH OF STAY IN lb

4 DAYS

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

HARFORD Memorial Hosp.

3. NAME OF
DECEASED
(Type or print)

Richard Wood

First

Middle

Last

5. SEX

MALE

White

10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Watchman

10b. KIND OF BUSINESS OR INDUSTRY

RETIRED

6. COLOR OR RACE

7. MARRIED

 NEVER MARRIED

8. DATE OF BIRTH

Aug. 13, 1887

74 yrs.

9. AGE (In years last birthday)

IF UNDER 1 YEAR

Months

Days

Hours

Min.

13. FATHER'S NAME

FRANK S. SAMPSON

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank or grade of service)

YES

16. SOCIAL SECURITY NO.

17. INFORMANT

11. BIRTHPLACE (County & State, or foreign country)

Virginia

14. MOTHER'S MARRIED NAME

MAGGIE Mc CALL

Address

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)

422 DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO

(c)

Cardiac Insufficiency
Chronic myocarditisINTERVAL BETWEEN
ONSET AND DEATH

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

19. WAS AUTOPSY PERFORMED?

YES NO 20c. TIME OF INJURY Month, Day, Year
Hour a.m.
p.m.20d. INJURY OCCURRED
While at work Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 11-24, 1961 to Dec. 8, 1961, that (I) (we) last saw the deceased alive on 12-8, 1961, and that death occurred at 6A.M. from the causes and on the date stated above.

22a. SIGNATURE

22c. PHYSICIAN'S NAME (Type)

ATTENDING PHYS.

MED. DIRECTOR

STAFF PHYS.

22b. DATE SIGNED

22d. ADDRESS

Harry de Grace MD

23a. BURIAL, CREMATION, REMOVAL (Specify)

BURIAL

DEC. 10/1961

23b. DATE THEREOF

ANGEL HILL Cem.

23d. LOCATION (City, town or county)

HAURE de GRACE

(State)

24. FUNERAL DIRECTOR'S SIGNATURE

R. Madison Mitchell Harry de Grace, Md.

ADDRESS

25a. REGISTRAR'S SIGNATURE

DEC 12 1961

DATE

25b. REGISTRAR'S SIGNATURE

C. S. Morris

OCT 12 1961

הה הילך אליך

וְאַתָּה

מִזְמָרָתְךָ בְּנֵי יִשְׂרָאֵל

~~בְּנֵי יִשְׂרָאֵל~~

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

14015

CERTIFICATE OF DEATH

13984

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE	
<i>HARFORD</i>		MARYLAND <i>md</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>House de Grace, Md</i>		c. LENGTH OF STAY IN 1b <i>50 days</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>House de Grace, Md</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Aberdeen</i>	
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH	
First <i>John</i>		Middle <i>Henry</i>	Last <i>Singleton</i>
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	
WIDOWED <input type="checkbox"/>		DIVORCED <input type="checkbox"/>	
Oct. 4, 1880		9. AGE (In years last birthday) <i>81</i> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer (Ret.)</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Farm</i>	
11. BIRTHPLACE (State or foreign country) <i>MD</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>James Singleton</i>		14. MOTHER'S MAIDEN NAME <i>MARY Sampson</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>216-18-7990</i>	
17. INFORMANT <i>Lillie Singleton, Aberdeen, Md.</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Thrombotic occlusion ant. desc. coronary artery</i> DUE TO <i>Arteriosclerotic heart disease</i> INTERVAL BETWEEN ONSET AND DEATH <i>10 yr.</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Gastric ulcer with massive haemorrhage</i> (c) <i>Dec. 3 1961</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II or item 18.) <i>Nov. 29 1961 to Dec. 3 1961</i>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i>Aberdeen</i> (County) <i>P.P.R.</i> (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>Nov. 29 1961</i> to <i>Dec. 3 1961</i> , that (I) (we) last saw the deceased alive on <i>Dec. 3 1961</i> , and that death occurred at <i>12 P.M.</i> from the causes and on the date stated above.			
22a. SIGNATURES <i>V.H. Rodman M.D.</i>		22b. DATE SIGNED <i>12-4-61</i>	
22c. PHYSICIAN'S NAME (Type) <i>Peter P. Rodman, M.D.</i>		22d. ADDRESS <i>Aberdeen, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>12/6/61</i>	
23c. NAME OF CEMETERY OR CREMATORIAL <i>Harford Memorial Gardens, Aberdeen, Md.</i>		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <i>John G. Tarring</i>		Terring ADDRESS <i>Funeral Home Aberdeen, Md.</i>	
25a. REC'D BY REGISTRAR <i>DEC 6 '61</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

2101

M

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 2985

1. PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
Harford				b. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Bel Air		c. LENGTH OF STAY IN 1b 50 Years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Bel Air	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Forge Hill Road				d. STREET ADDRESS Forge Hill Road	
3. NAME OF DECEASED (Type or print)		First Mary	Middle A.	Last Smith	4. DATE OF DEATH December 29, 1961
5. SEX F	6. COLOR OR RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 30, 1879	9. AGE (In years 82 birthday) yrs. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY Housework		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Harrison Preston		14. MOTHER'S MAIDEN NAME Mary Gordon		12. CITIZEN OF WHAT COUNTRY U. S. A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 213-20-2717		17. INFORMANT (Son) Mr. L. Gerald Smith Bel Air, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Metastatic Carcinoma			
171X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		DUE TO Carcinoma of Cervix			
(c)		INTERVAL BETWEEN ONSET AND DEATH 1 month			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Malnutrition & arteriosclerotic cardiovascular disease		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. g. p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
19					
21. I certify that I attended the deceased from December 28, 1961 , to December 29, 1961 , that I last saw the deceased alive on December 28, 1961 , and that death occurred at 9:30 PM , from the causes and on the date stated above.					
ADDRESS (Street, city or town, state) Hickory, Harford Co., Md.					
DATE SIGNED 12/30/61					
ACTUAL SIGNATURE Paul S. Stonesifer Jr.		M.D.			
PHYSICIAN'S NAME (Type) PAUL S. STONESIFER JR.		12/30/61			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 2, 1962		22c. NAME OF CEMETERY OR CREMATORIAL St. Ignatius Gem.	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph W. Foster		22d. LOCATION (City, town, or county) (State) Hickory, Harford Co., Md.			
		24a. REC'D BY REGISTRAR Arthur S. Kraus			
		24b. REGISTRAR'S SIGNATURE DATE JAN 2 '62			

CERTIFICATE OF DEATH

Date of birth _____

Cause of death _____

Date of death _____

Name of deceased _____

MASSACHUSETTS

DEPARTMENT OF THE COMMONWEALTH

MASSACHUSETTS DEPARTMENT OF THE COMMONWEALTH

MASSACHUSETTS DEPARTMENT OF THE COMMONWEALTH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.

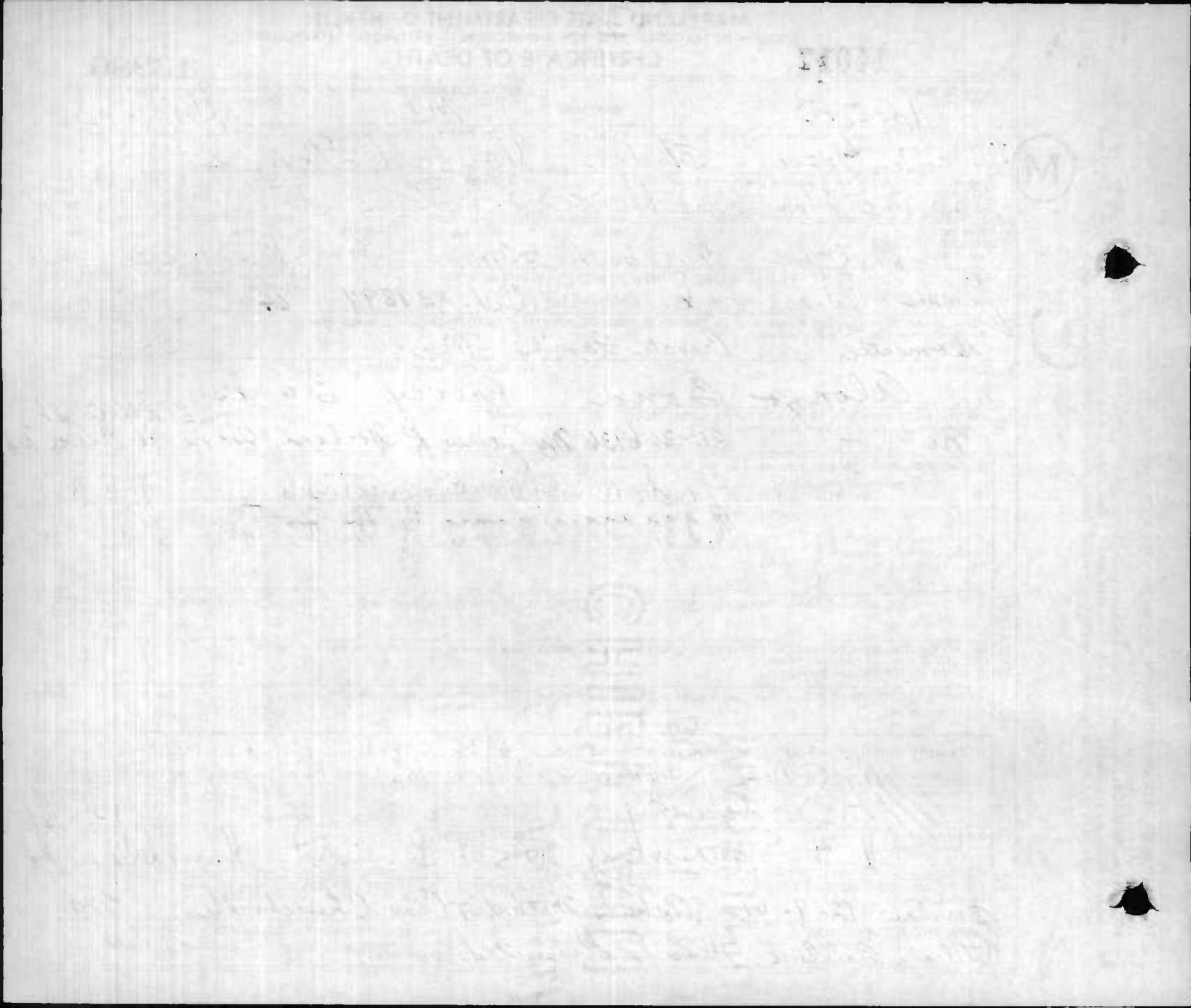
MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

14017

CERTIFICATE OF DEATH

13986

1. PLACE OF DEATH a. COUNTY <i>Harcord</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hause de Grace</i>		b. COUNTY <i>Harcord</i>	
c. LENGTH OF STAY IN 1b <i>36 days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hause de Grace 24</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Harcord Memorial Hospital</i>		d. STREET ADDRESS <i>251 Lewis St.</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>Myrtle</i>	Middle <i>Elizabeth</i>	Last <i>Smith</i>
4. DATE OF DEATH	Month <i>December</i>	Day <i>5</i>	Year <i>1961</i>
S. SEX <i>female</i>	A. COLOR OR RACE <i>Colored</i>	B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	C. DATE OF BIRTH <i>Oct. 23, 1897</i>
D. AGE (In years last birthday) <i>64 yrs.</i>	E. IF UNDER 1 YEAR Months <i>25</i>	F. IF UNDER 24 HRS. Days <i>1</i>	G. Hours <i>0</i>
10c. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Domestic</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Private Family</i>	11. BIRTHPLACE (State or foreign country) <i>Md.</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>
13. FATHER'S NAME <i>Alonzo Bond</i>	14. MOTHER'S MAIDEN NAME <i>Provey Banks</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>213-30-6936</i>	17. INFORMANT <i>Mr. James F. Holland, Hause de Grace Md.</i>	Address <i>251 Lewis St., Hause de Grace Md.</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Abdominal Carcinomatosis</i>		INTERVAL BETWEEN ONSET AND DEATH <i>Not known</i>	
153.8 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		DUE TO <i>Adenocarcinoma of the Colon</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>10/30 1961</i> to <i>12/5 1961</i> , that (I) (we) last saw the deceased alive on <i>Dec. 5 1961</i> , and that death occurred at <i>10A</i> M, from the causes and on the date stated above.			
22a. SIGNATURE <i>V. H. Sadowsky</i>	M.D. <input type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <i>12/5/61</i>	
22c. PHYSICIAN'S NAME (Type) <i>V. H. SADOWSKY, MD</i>	22d. ADDRESS <i>504 Lewis St. Hause de Grace, Md.</i>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>12-9-61</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Asbury Methodist Cem.</i>	23d. LOCATION (City, town, or county) (State) <i>Churchville, Md.</i>
24. FUNERAL DIRECTOR'S SIGNATURE <i>Otelia J. Bullock, Hause de Grace, Md.</i>	ADDRESS	25a. REC'D BY REGISTRAR DATE <i>DEC 8 '61</i>	25b. REGISTRAR'S SIGNATURE <i>Arthur S. Knapp</i>



M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
14018

CERTIFICATE OF DEATH

Reg. Dist. No. 1387

1. PLACE OF DEATH a. COUNTY HARFORD		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) STREET		c. LENGTH OF STAY IN 1b 1 yr.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X STREET	
3. NAME OF DECEASED (Type or print) MARY		First VIRGINIA	Middle SMITHSON
4. DATE OF DEATH December 3 1961	Month Day Year		
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH November 1, 1960
8. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ---		9. AGE (In years lost birthday) yrs. 1	
10b. KIND OF BUSINESS OR INDUSTRY ---		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME William Lee Smithson		14. MOTHER'S MAIDEN NAME Mabel Marie Hopkins	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) ---		16. SOCIAL SECURITY NO. ---	
17. INFORMANT William Lee Smithson		Address Jerry Rd., Street, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Laryngotracheobronchitis and bronchopneumonia		INTERVAL BETWEEN ONSET AND DEATH 2 days	
DUE TO 501X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) obesity		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from December 2, 1961 to December 3, 1961 , that I last saw the deceased alive on December 3, 1961 , and that death occurred at 10:30A.M. from the causes and on the date stated above. ACTUAL SIGNATURE Paul S. Stonesifer Jr.		ADDRESS (Street, city or town, state) 115 Fulford Ave. Bel Air, Md.	
PHYSICIAN'S NAME (Type) PAUL S. STONESIFER, JR., M. D.		DATE SIGNED 12/3/61	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 5, 1961	
22c. NAME OF CEMETERY OR CREMATORIAL Slate Ridge		22d. LOCATION (City, town, or county) Delta, Penna.	
23. FUNERAL DIRECTOR'S SIGNATURE John H. Hawkins		ADDRESS Delta, Pa.	
24a. REC'D BY REGISTRAR DATE DEC 5 '61		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

STATE DEPARTMENT OF HIGHWAY-SAFETY
CERTIFICATE OF SAFETY

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

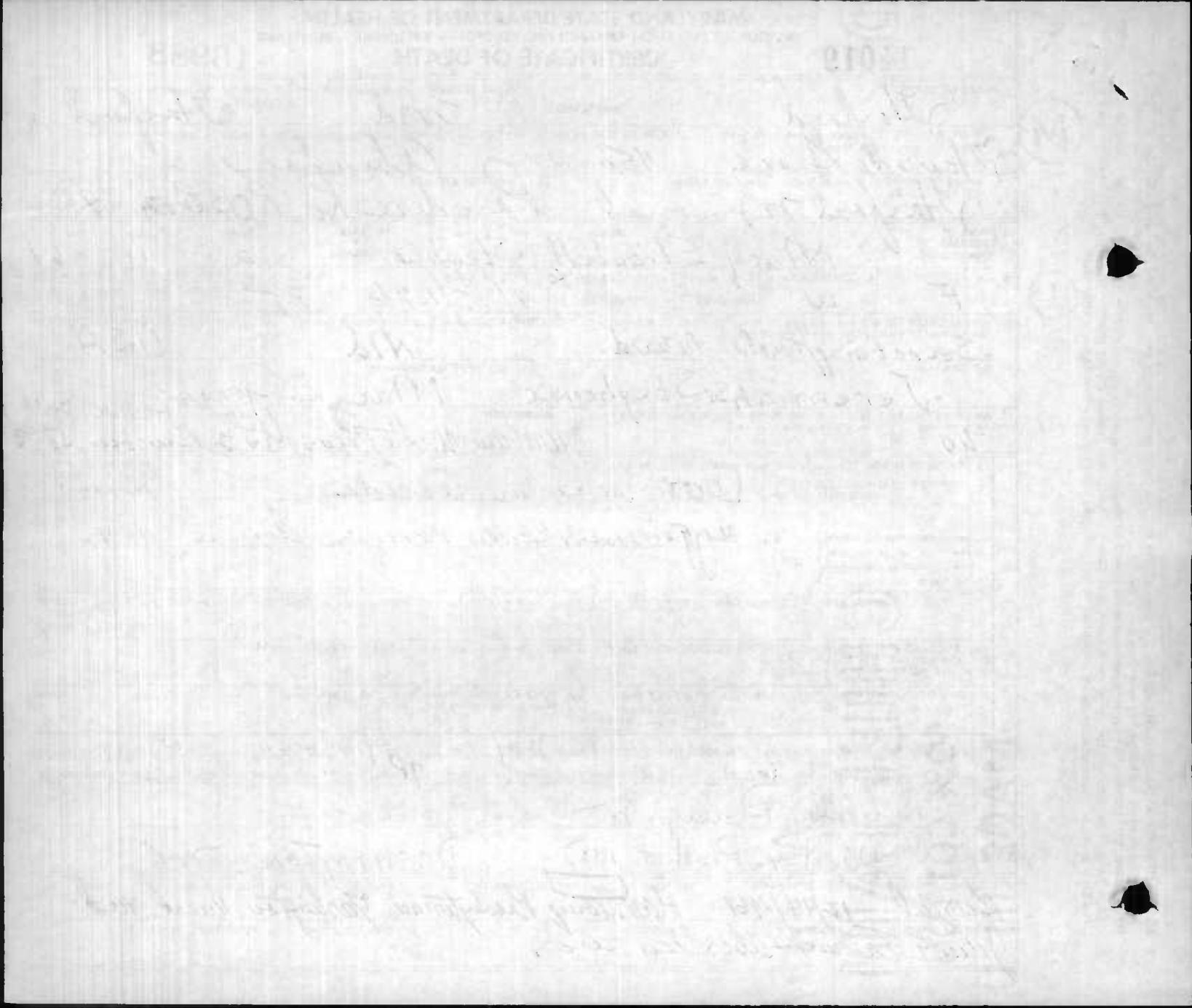
MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

14019

CERTIFICATE OF DEATH

13988

1. PLACE OF DEATH a. COUNTY <i>Harford</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Harford</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Harford Grace</i>		c. LENGTH OF STAY IN 1b <i>45 min</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Harford Memorial</i>		e. STREET ADDRESS <i>Aberdeen Paradise Rd RD2 Box 34</i>	
3. NAME OF DECEASED (Type or print) <i>Mary Elizabeth Stephens</i>		First <i>Mary</i>	Middle <i>Elizabeth</i>
		Last <i>Stephens</i>	4. DATE OF DEATH <i>12 11 1961</i>
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>9/15/1876</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Secretary/Teacher</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Retired</i>	11. BIRTHPLACE (State or foreign country) <i>Nd</i>
13. FATHER'S NAME <i>Jeremiah S. Stephens Sr</i>		14. MOTHER'S MAIDEN NAME <i>Mary E. Jones</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>653 247-00</i>	17. INFORMANT <i>William M. Stephens</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>443X</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>Hypertension</i>		DUE TO <i>Orchovascular Accident</i>	
		(b) DUE TO <i>Caecus Vasculitis claudina</i>	INTERVAL BETWEEN ONSET AND DEATH <i>1 MIN</i>
		(c)	10 gm
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>May 12 1957</i> to <i>Dec 11 1961</i> , that (I) (we) last saw the deceased alive on <i>Dec 11 1961</i> , and that death occurred at <i>7P.M.</i> from the causes and on the date stated above.		22b. DATE SIGNED	
22a. SIGNATURE <i>Dudley Phillips MD</i>		M.D. <input type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <i>Dudley Phillips MD</i>		22d. ADDRESS <i>Darlington Md</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>12/14/1961</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Harmony Presbyterian</i>
24. FUNERAL DIRECTOR'S SIGNATURE <i>John G. Barrang - Aberdeen, Md.</i>		ADDRESS	25a. REC'D BY REGISTRAR DATE <i>DEC 19 '61</i>
			25b. REGISTRAR'S SIGNATURE <i>Arthur S. Krause</i>



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

FOR STATE
HEALTH DEPT.

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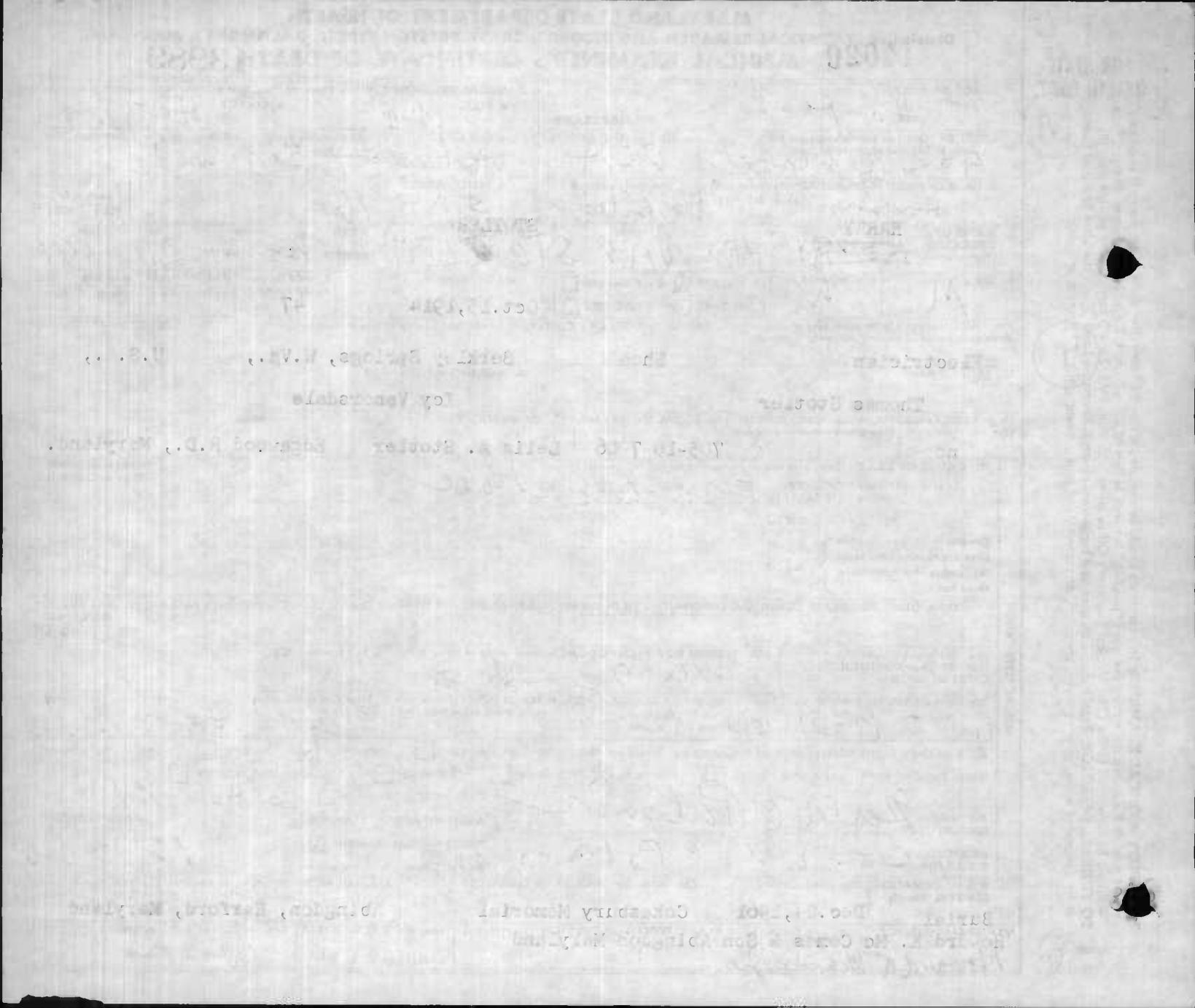
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DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

O FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15M
5M 9/60

1. PLACE OF DEATH e. COUNTY		Harford		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		Amen de grace		DOA		e. STATE	
c. LENGTH OF STAY IN lb				nd		b. COUNTY	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		Harford Memorial Hospital		X Abingdon Edgewood		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)	
3. NAME OF DECEASED (Type or print)		HARRY	First	Middle	STOTTLER	d. STREET ADDRESS	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
		#			1 S R B 16		
5. SEX		M	6. COLOR OR RACE	W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	4. DATE OF DEATH
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		Electrician		Shoe		Oct. 15, 1914	Month Dec Year
10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME		Thomas Stotler		Berkley Springs, W.Va.,		U.S.A.,	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank or date of service)		no		16. SOCIAL SECURITY NO.		14. MOTHER'S MAIDEN NAME	
				705-10-7206		Lelia A. Stotler	Address
18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).]		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e)		Fracture skull		Edgewood R.D., Maryland.	
825X		DUE TO				INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b)		DUE TO					
(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(e)							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)		20c. TIME OF INJURY Month, Day, Year Hour <input type="checkbox"/> p.m. 12-21 1961		20d. INJURY OCCURRED While <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
		A auto accident		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) Edgewood Sa Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>Terrie C Palmer</i> CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <i>Baltimore, Md.</i> EXAMINER'S NAME (Type) <i>Ct-21d C Palmer-110</i> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <i>12-32-6</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIUM		22d. LOCATION (City, town, or country) (State)	
Burial		Dec. 24, 1961		Cokesbury Memorial		Abingdon, Harford, Maryland (State)	
23. FUNERAL DIRECTOR		Howard K. McComas & Son		ADDRESS		24a. REC'D BY REGISTRAR	
		Abingdon Maryland				24b. REGISTRAR'S SIGNATURE	
						Arthur S. Trahan	
						DATE DEC 27 '61	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14021

CERTIFICATE OF DEATH

13990

1. PLACE OF DEATH
a. COUNTY

Harford

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Haure de Grace

c. LENGTH OF STAY IN lb

1 day

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Harford Memorial

3. NAME OF
DECEASED
(Type or print)

Sarah

First

Middle

Last

4. DATE
OF
DEATH

Month

Day

Year

12 18 1961

5. SEX

F

6. COLOR OR RACE

W

7. MARRIED NEVER MARRIED WIDOWED DIVORCED

8. DATE OF BIRTH

July 18-1938

9. AGE (in years
last birthday)

23 yrs.

IF UNDER 1 YEAR

Months Days

IF UNDER 24 HRS.

Hours Min.

10e. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Secretary

10b. KIND OF BUSINESS OR INDUSTRY

U.S. Govt.

11. BIRTHPLACE (County & State, or foreign country)

Pa

12. CITIZEN OF WHAT COUNTRY?

45A

13. FATHER'S NAME

Howard Woodruff

14. MOTHER'S MAIDEN NAME

Mrs Robert Mitchell - Box 3022

15. WAS DECEASED EVER IN U.S. ARMED FORCES?

(Yes, no, or unknown) (If yes give rank or dates of service)

16. SOCIAL SECURITY NO.

P. INFORMANT

Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (e)

260X

DUE TO

(b)

DUE TO

(c)

Diabetic Acidosis

Diabetes Mellitus

INTERVAL BETWEEN
ONSET AND DEATH

2 days

3 months

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)

19. WAS AUTOPSY
PERFORMED?YES NO 20a. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m. 12
p.m. 1920d. INJURY OCCURRED
While at work Not While at work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Dec 18th, 1961, to Dec 18th, 1961, that (I) (we) last saw the deceased alive on Dec 18th, 1961, and that death occurred at 10 P.M. from the causes and on the date stated above.

22e. SIGNATURE

Edward C. Loo, M.D.

ATTENDING
PHYS.MED.
DIRECTORSTAFF
PHYS.22b. DATE
SIGNED
Dec 18th, 196122c. PHYSICIAN'S
NAME (Type)

Edward C. Loo, M.D.

22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial23b. DATE THEREOF
12/21/196123c. NAME OF CEMETERY OR CREMATORIAL
Harborby Presbyterian23d. LOCATION (City, town or county) (State)
Baltimore, Harford Co. Md.24. FUNERAL DIRECTOR'S SIGNATURE
John F. Farren - Chesapeake Maryland

ADDRESS

25e. REC'D BY REGISTRAR
DEC 26 '6125b. REGISTRAR'S SIGNATURE
Arthur S. Kline

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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